

**EVALUATION OF THE CENTRE FOR  
DEVELOPMENT AND POPULATION  
ACTIVITIES (CEDPA) ACCESS TO  
FAMILY PLANNING THROUGH  
WOMEN MANAGERS PROJECT  
(936-3059)**

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## ABBREVIATIONS

ACCESS	ACCESS to Family Planning Through Women Managers Project
AIC	AIDS Information Center
AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
APWA	All Pakistan Women's Association
ASDAP	Association de Soutien aux Developpement des Activites des Population (Association for Health and Population Activities)
AVSC	AVSC International
AWC	African Women's Caucus
BLE	Better Life Education
CA	Cooperating Agency
CBD	community-based distribution
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CEOSS	Coptic Evangelical Association of Social Services
COMPFED	Cooperative Milk Producers Federation
CTO	cognitive technical officer
CTU	Contraceptive Technology Update
CYP	couple years of protection
DCS	dairy cooperative societies (Bihar)
DH	depot holder (NRC trainee)
FLPS	Family Life Promotion and Services
FP	Family Planning
FPAK	Family Planning Association of Kenya
FPAN	Family Planning Association of Nepal
FW	field-worker
FY	Fiscal Year
GSCPT	Gujarat State Crime Prevention Trust
GTZ	Association for Technical Cooperation (a German development agency)
HEAL	Health Education Adult Literacy
HIV	human immunodeficiency virus
IB	institution building
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
IEC	information, education, and communication
IFPS	Innovations in Family Planning Services
ITRFP	Institute for Training and Research in Family Planning
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	Johns Hopkins University
JSI	John Snow, Inc.
LEAP	Leadership, Education, and Advocacy Program
MCH	maternal and child health

MIS	management information system
MOH	Ministry of Health
MYWO	Maendeleo Ya Wanawake Organization
NGO	nongovernmental organization
NRC	Nigerian Railways Corporation
NRCS	Nepal Red Cross Society
ODA	Overseas Development Agency
PACT	Private Agencies Cooperating Together
PCS	Population Communication Services
POPTECH	Population Technical Assistance Project
PPFN	Planned Parenthood Federation of Nepal
PPRC	Prerana Population Resource Center
PROFIT	Promoting Financial Investments and Transfers
PSI	Population Services International
PSS	Parivar Sewa Sanstha - Marie Stopes International
PVO	private voluntary organization
QOC	quality of care
RAPID	Resources for the Awareness of Population Impact on Development Project
RFHP	Rural Family Health Project
SEATS	Family Planning Services Expansion and Technical Support Project
SIFPSA	State Innovations in Family Planning Services Agency
SOMARC	Social Marketing for Change Project
STD	sexually transmitted disease
TA	technical assistance
TOT	training of trainers
UNFPA	United Nations Population Fund
UNIFEM	United Nations Organization for Women
UP	Uttar Pradesh State, India
USAID	United States Agency for International Development
VHW	village health worker
VSC	voluntary surgical contraception
WHO	World Health Organization
WID	Women in Development
WIM	Women in Management
YWCA	Young Women's Christian Association

# EXECUTIVE SUMMARY

## Background

The Centre for Development and Population Activities (CEDPA) ACCESS to Family Planning Through Women Managers Project (ACCESS) was launched in 1991, through a Cooperative Agreement with the United States Agency for International Development Office of Population. In 1994, USAID raised the Cooperative Agreement ceiling from US\$15.6 million to US\$27 million, and extended the project for one year, from August 1996 to August 1997.

The goal of the ACCESS project is to improve the health and well-being of women through family planning. The project is intended to: (a) lower fertility through increased access to quality family planning services, and (b) help ensure that unmet demand for these services is addressed through provision of appropriate financial, technical, and human resources.

## Evaluation Purpose and Methodology

The purpose of the evaluation was to address the following USAID questions, among others:

- To what extent has ACCESS accomplished the purpose set out in the project agreement?
- What models and strategies does ACCESS use to accomplish its objectives?
- To what extent has CEDPA empowered the women whom it has trained?
- How have the organization, management, and finances of the ACCESS project influenced its accomplishments and capacity for future expansion?
- How, and to what extent, has the project provided quality family planning to women, particularly young, low-parity women?
- To what extent are local organizations more sustainable, especially, institutionally sustainable as a result of receiving support from ACCESS?
- What needs or issues that are not dealt with in the project should be addressed in a follow-on project?

Sources of data for the evaluation included service statistics from all subprojects, an extensive collection of project documents, CEDPA internal evaluations, and interviews in Washington, D.C. The evaluation team received electronic mail messages from USAID Missions in Kenya, India, Nepal, and Nigeria, and held telephone interviews with CEDPA staff and USAID Mission staff in Nepal, Tanzania, Nigeria, Mali, and Egypt. During ten days in the field, the team visited all four active projects in Kenya and three projects in India. In India, the team also met with the Prerana Population Resource Center, the ACCESS-sponsored training organization. In each country, the team interviewed project staff, USAID Mission Population, Health, and Nutrition officers, people who are knowledgeable about CEDPA's work (such as other cooperating agencies and

nongovernmental organizations), and CEDPA alumni. The team conducted a total of more than 120 interviews, including interviews with 22 alumni of CEDPA's Women in Management (WIM) training, and held 10 group interviews with community-based distribution (CBD) workers and clients.

## **Achievement of Objectives**

The key project objectives (1991-1997), as amended in Fiscal Year (FY) 1994, are to

- a) expand quality, cost-effective service delivery, and promote more effective methods
- b) enhance women's participation in family planning
- c) strengthen the capacity of institutions to support sustainable family planning services
- d) cluster subprojects strategically in the three regions of Africa, Near East, and Asia
- e) develop field resources to support subprojects
- f) provide short-term technical assistance to develop and strengthen family planning programs
- g) provide expertise in planning, management, training, program design, implementation, and evaluation

ACCESS has met or exceeded all but one of the objectives set forth in the project amendment. The planned Consultant Corps objective of training 75-100 individuals was not achieved due to problems in the design. As follow-up, plans have been developed to revise the training program and train an additional 40-50 ACCESS alumni over the next 18 months. In Nigeria, however, ACCESS trained over 50 master trainers to serve as trainers for other subprojects.

CEDPA/ACCESS has followed-up on the recommendations of the previous USAID evaluation and has made noteworthy progress in management and financial systems, monitoring and evaluation, quality of care, integration of reproductive health systems, and institutional and financial sustainability. Overall, the findings of the current evaluation team are positive. As with any project, there are areas of greater and lesser accomplishment and some implementation difficulties. Nevertheless, the evaluation team focused particularly on the progress made since the last evaluation.

All USAID Missions the team contacted commended ACCESS for its excellence, flexibility, and responsiveness in management.

## **CEDPA's Model for Sustainable Development**

CEDPA's approach to development involves a synergistic interaction between training, long-term partnerships, empowerment, and technical assistance. The model functions

simultaneously at the level of the individual woman and of the nongovernmental organization or community group she belongs to.

Key elements of the model are: (1) partnership, with an emphasis on participation by the community and the individual in decisions concerning reproductive health, (2) empowerment, and (3) institutional strengthening.

## **Empowerment**

Empowerment is an integral element of ACCESS's work. ACCESS uses four principal strategies for empowering women: employment of female workers, advocacy and leadership development, training, and service delivery. At the community level, women who had never held jobs before and who rarely left their homes are now trained as CBD workers. At least 2,773 women have been trained as community outreach workers. Research conducted by CEDPA on changes in CBD workers' lives in seven countries found that the workers perceived some improvement in their economic status, knowledge and skills, better relationships with their husbands, and increased decision making within their household. In Egypt, ACCESS-trained women who were not previously substantively involved in village meetings have now become outspoken advocates for reproductive health issues. In Nepal, ACCESS trained women as family planning field-workers and educated male supervisors in gender issues. By providing an important service in their communities, the women report having greater control over their own life. At the managerial level, ACCESS reports that it trained 82 women as CBD supervisors, 76 women in subproject management, and 54 in providing administrative support.

Over a period of 20 years, CEDPA and ACCESS have provided Women in Management (WIM) training to more than 4,000 women in developing countries. Several of these women have now achieved positions of importance and influence in their country. This group, therefore, represents a unique and significant resource for in-country advocacy. ACCESS, with the International Center for Research on Women (ICRW), has developed indicators to measure women's empowerment but has not yet examined the relationship between empowerment and program outcomes in a comprehensive way that relates to a strategic plan.

## **Technical Assistance, Training, and Institutional Strengthening**

Each ACCESS subproject includes technical assistance, training, and hands-on support aimed at achieving sustainability and independence from CEDPA. Technical assistance provided by ACCESS has been timely and of good quality, which has resulted in the improvement of access and service quality. In Kenya, for example, ACCESS provided a range of technical assistance which substantially improved the performance of the Kabiyo Kawangware Community Health Project. This project had been supported by other donors for many years, yet had few family planning acceptors. ACCESS provided WIM training for the project manager, and refresher courses for CBDs. Regional



ACCESS staff also provided support for creating an effective service delivery system. With more than 80 percent of the subproject completed, ACCESS has now achieved 355 percent of the targeted number of new acceptors. ACCESS has developed a range of management tools for institutional strengthening and has been successful in establishing solid management

Insert CEDPA Model for Sustainable Development

and financial systems in its subprojects. ACCESS needs to develop ways to assess the impact and effectiveness of its training and technical assistance activities and to ensure that its subproject management tools are used consistently in ongoing monitoring activities.

## **Family Planning Service Delivery**

ACCESS has established effective and, in many cases, innovative strategies for delivering quality family planning services to highly disadvantaged groups in difficult to reach geographic areas and challenging environments. In 1995, ACCESS had a total of 20 subprojects under way in five countries: India, Nepal, Kenya, Nigeria, and a subproject is about to begin in Tanzania. The subprojects have achieved important results in various areas. A summary of these results, based on analyses of ACCESS service statistics, is presented in Box 1.

(ACCESS defines new clients as those clients that are new to the project. Data on both new clients and new acceptors (those clients who are new to family planning) are gathered at the subproject level. All referrals in ACCESS are "effective referrals." An effective referral is defined as a client for whom a written [in most cases] confirmation has been prepared documenting that a contraceptive method has been received by the client. ACCESS added the indicator of "effective referrals" to its monitoring and evaluation system in 1993.)

ACCESS has designed and implemented several service delivery models that appear promising. Two models--one involving the addition of family planning to an ongoing urban social services program, the other involving the addition of family planning to a dairy cooperatives program--are both being successfully replicated in Uttar Pradesh, India, under the USAID Innovations in Family Planning Project. The evaluation team's 10 group meetings with CBD workers and clients in India and Kenya suggested good quality of care. While client satisfaction and related studies are planned, ACCESS has not yet examined continuation rates, an important indicator of quality of care, in a systematic way. Drop out data have been collected only recently in a few subprojects. Project staff acknowledge that these data are not yet reliable. These issues will need to be addressed for ACCESS to continue to make improvements in quality of care.

ACCESS's knowledge of service delivery issues at the local level, coupled with its expanding in-country alumni base of trained and articulate leaders, gives the project a unique comparative advantage in the areas of advocacy for family planning and reproductive health. In considering which types of advocacy groups to support, USAID should consider recent research findings on the types of advocacy activities that are critical for policy reform (Crouch et al., 1994; Porter 1995). These studies contend that (a) policy reform, frequently a long and slow process, is more likely to occur when local groups understand the issues, feel they have a stake in and ownership of the process, and become mobilized to undertake advocacy on their own; (b) donor funding of advocacy groups that have minimal roots in local communities is less likely to lead to genuine and meaningful reform; and (c) policy reform at the national level is greatly

facilitated by support from the local level. These findings would argue for USAID to support community-level service delivery activities that are closely linked to advocacy.

## Box 1

### Achievements and Results in ACCESS Subprojects

*Service Delivery Results.* By 1995, ACCESS had achieved 90 percent of its six-year goal for service delivery in less than four years, serving 392,079 new clients and referrals between September 1991 and December 1994. Matrix 1, ACCESS Service Delivery Strategies, provides additional data for the individual subprojects which support this statement. For each subproject, the matrix provides data on new clients recruited, as a percentage of the objective, compared to the percentage of the subproject completed to date.

*New Clients.* A 1995 in-depth review of ACCESS service statistics concluded that "CEDPA's field programs are attracting substantial numbers of new clients throughout each project period. While the numbers are generally higher during the first two years..., recruitment of new users continues at very significant levels thereafter. This is true even after two to three years of operation, suggesting greater penetration into the target population as the project matures."

*Low Parity.* ACCESS is reaching low-parity women. The largest client group it serves has two children per woman, while the second and third largest groups served have three children and one child per woman, respectively. ACCESS subprojects are "predominantly and almost uniformly attracting low-parity women; the pattern of recruitment is pronounced and unequivocal." (See Table 1 - New Clients by Parity.)

*Young Age.* ACCESS is reaching young women. In subprojects for which data are available, the largest client group is in the 25-29 age group, while the second largest group served is in the 20-24 age group. (See Table 2 - New Clients by Age Group and Subproject.)

*Method Switching.* Data analyses show that "method switching is very heavily oriented in the desired direction; that is, from less effective to more effective contraceptive methods." For example, clients are switching from:

Pill	to	Depo-Provera, IUD, and VSC Female
Condom	to	Pill, Depo-Provera, IUD, and VSC Female
Depo-Provera	to	VSC Female
IUD	to	Depo-Provera and VSC Female

*Subproject Implementation Progress.* For the eight ongoing service delivery projects (seven in Nigeria provide technical assistance only, and one in India is a training project), all are on target with the projected number of new clients and referrals (except Nepal Red Cross). And several subprojects have substantially exceeded the projected new client levels (FLPS, Kabiro-Kawangware, MaendeleoYa Wanawake and Family Planning Association of Kenya, in Kenya).

*New Client, Referral, and CYP Trends.* Overall, new client, referral and CYP trends are positive to date. (See Table 3 - Subproject Objectives, Expected Results and Achievements, March 1991-1995.)

Source: Trayfors, 1995. All quotations in this box are taken from the 1995 Trayfors analysis.

Insert Table 1

Insert Table 2

Insert Table 3



Insert Table 3

Insert Table 3

## **Sustainability**

ACCESS has taken important steps toward developing an integrated sustainability strategy, that aims to advance family planning organizations along a continuum toward institutional, financial, and political sustainability. ACCESS works with partners to encourage financial sustainability through the development of management systems, the preparation of long-range strategies for sustainability and the diversification of funding (cost recovery, social marketing, fee for service, multiple donors, community contribution). Out of eight service delivery subprojects (excluding Nigeria), six have multiple options for funding diversification. Two have revolving drug funds, four charge a fee for service or registration fee, and two participate in the social marketing of condoms. The Mali *Association de Soutien aux Developpement des Activites des Population* (ASDAP, the Association for Health and Population Activities project), which has now graduated, has had income generation activities for several years and is charging for providing training to other nongovernmental organizations (NGOs). All projects which generate funds have developed systems to properly account for funds and supplies. ACCESS has honored its commitment to partners even when subproject funding was cut due to changing USAID policy and priorities. In all cases it leveraged alternative funding and supported partners to continue activities. Eleven of twelve projects have continued. Only the Turkish Municipal project has closed due to changes in political support. While ACCESS is working with its partners to develop financial sustainability, only two of the current subprojects have embarked on an assessment of the full costs of service delivery. This area of sustainability will require ACCESS's greatest attention.

## **Management, Strategic Planning, and Monitoring and Evaluation**

CEDPA has made dramatic progress in its management systems since the last evaluation. Management systems used for the ACCESS project are as sophisticated as those of other development organizations. The project's excellent monitoring and evaluation system is based on the gathering of service statistics in all subprojects. ACCESS/Washington reviews the subproject data each quarter and provides feedback on findings and data quality at that time. In 1995, an external review of ACCESS's data concluded that "CEDPA's data collection system seems to be working well and, while there is certainly room for improvement, is a valuable source for useful information pertaining to CEDPA's field activities" (Trayfors, 1995). All USAID Missions who were contacted during the evaluation commented on the usefulness of ACCESS's field offices and the importance of having ACCESS nearby for collaboration and discussion. ACCESS has an excellent financial reporting system. While CEDPA prepared a strategic plan in 1992, it is descriptive and includes neither clear policy guidance, nor realistic, measurable objectives linked to indicators and a performance monitoring and evaluation plan.

## Models of Partnership

ACCESS has developed the following models for partnership with other organizations to support sustainable development. After additional implementation experience, these models will need to be compared and evaluated.

1. The traditional approach involves CEDPA/ACCESS channeling CEDPA resources (training, technical assistance, and funding) to nongovernmental organizations while simultaneously training women in the organization in leadership and management. One of the criticisms of this model was that even if this approach were successful, broader effects (at the state, provincial, or regional level) would be minimal. To attempt to address this criticism, ACCESS has developed other models which include the following.
2. In India, CEDPA is the lead among 17 Cooperating Agencies (CAs) who are charged with implementing a statewide family planning program in Uttar Pradesh. Theoretically, this model allows ACCESS to scale-up and provide an infusion of technical assistance and skills to grassroots organizations throughout the state.
3. Another model involves ACCESS's work with training centers and emphasis on the training of trainers (as in Nigeria) to reach many more grassroots organizations with its training and technical assistance.
4. Also in Nigeria, another model involves ACCESS's work to provide family planning through a broad range of "existing networks" such as urban markets, the informal business sector, women's cooperatives, trading and religious associations and agricultural workers.
5. In Uttar Pradesh, ACCESS is developing a strategy to work with "consortiums of NGOs," rather than with one single NGO at a time, and to strengthen lead NGOs in the consortium, as an effort to reach more groups at the local level.

In Nepal, ACCESS is providing family planning through the infrastructure of the Red Cross, a long-established organization in Nepal that has offices and sites throughout the country. And in Bihar and Uttar Pradesh, ACCESS is providing services through the rural infrastructure of dairy cooperatives.

# RECOMMENDATIONS

## Major Conclusions and Recommendations

### Service Delivery and Advocacy

#### Conclusion

ACCESS's holistic and integrated model for sustainable development and quality service delivery--with its emphasis on empowerment, participation and institutional strengthening--is an effective approach for increasing contraceptive prevalence. ACCESS's ongoing relationship with the in-country network of CEDPA alumni, coupled with its linkages with local communities, and its knowledge of service delivery issues at the local level, gives CEDPA a unique comparative advantage with respect to advocacy for family planning and reproductive health. Recent research holds that reform is more likely when local communities understand and feel ownership of the issues and can initiate advocacy at the grassroots.

#### Recommendation

1. ACCESS should continue to focus on both service delivery and advocacy. USAID should consider ways in which CEDPA can play a leadership role in the design, implementation, and management of family planning and reproductive health service delivery in the nongovernmental sector, especially in situations where USAID can employ CEDPA's comparative advantage. CEDPA/ACCESS should encourage its alumni to use lessons and experience from service delivery in its advocacy efforts. (p. 69)

### Sustainability

#### Conclusion

ACCESS has taken important steps toward developing an integrated sustainability strategy. The strategy includes a systematic process of interventions which strengthens institutions' management, financial, and human resource systems and mobilizes community support and ownership.

#### Recommendation

2. To continue to make progress in both institutional and financial sustainability, and to increase efficiency and cost-effectiveness, CEDPA should: (a) develop its capacity to determine the full costs of service delivery and institutional strengthening as well as monitor cost trends in CEDPA itself and its subprojects; and (b) continue to develop collaboratively with its partners' agreed upon plans

for financial sustainability, as part of a strategic emphasis on entrepreneurial thinking and activities. (p. 69)

## **Management**

### Conclusion

ACCESS has excellent management systems in place and the institutional capacity to support additional subprojects. Nevertheless, the CEDPA strategic plan does not yet optimally guide management decisions and implementation.

### **Recommendation**

3. (a) USAID should seek opportunities to introduce and implement CEDPA's tested service delivery strategies on a larger scale, in additional country settings, to increase coverage and contribute to broader (provincial or state) results and impact. (b) CEDPA should develop a new strategic plan with clear and measurable objectives that is monitored on a regular basis and is linked to an evaluation plan and costing studies. (p. 70)

## **Future Directions**

### Conclusion

The design of a possible follow-on project should take into consideration CEDPA's comparative advantage.

### **Recommendation**

4. CEDPA should consider adding to its current program the following as areas for future focus: (a) a focus on education in family planning and reproductive health for youth, ages 10-18 (both boys and girls), which would incorporate the lessons and experience of the Better Life Education project; (b) support for the development of strategic, country-specific plans for advocacy by the CEDPA alumni; and (c) a strategic focus on entrepreneurial training and activities. (p. 70)

## **Additional Recommendations**

### **Empowerment**

5. To reduce the risk of early and unplanned pregnancy, ACCESS should include in its empowerment activities a focus on young girls, 13-18 years of age by (a) developing self-esteem and skills building courses for this group; and (b) implementing Alumni mentoring activities which support young women. (p. 16)
6. Using simple data collection methods, ACCESS, should test the indicators of empowerment of women in Nigeria that it developed with ICRW in other projects. ACCESS should continue to examine the extent to which empowerment strategies affect program outcomes and consider including these topics in the strategic plan. Important questions are: do empowerment strategies affect program outcomes? Do they result in "better" program outcomes than more traditional service delivery strategies? (p. 16)
7. CEDPA needs to develop ways to track WIM participants over time to monitor their empowerment and their effect on women in their country as they move up in their career. While the anecdotal information on WIM participants is impressive, it could be systematized. (p. 16)
8. As women can only advance as men's perceptions of them change, CEDPA's Training Division needs to undertake extensive Training of Trainers (TOT) on gender sensitivity for men at all levels, from senior government officials down to school boys. ACCESS should develop some short, simple activities that CBD workers could include in their information, education, and communication (IEC) efforts. (p. 17)
9. In India, elections were recently held for *Panchayat* (community council) members; by law, one-third of council members are women. Very few of these women have any leadership training, and most are seen as fronts for their husbands. Building on CEDPA's very successful experience of training women in Egypt, CEDPA (with assistance from USAID/India) should discuss with this group whether CEDPA training in leadership, assertiveness, and management would be desired. (p. 17)

### **Technical Assistance, Training, and Institutional Strengthening**

10. Since CEDPA's training partners have the opportunity to multiply the impact of ACCESS training and technical support, these institutions need to be provided with technical assistance to sustain the quality of their work and expand their areas of expertise to include management-related training on reproductive health, community health, and gender issues. ACCESS/Washington should examine ways to ensure the most cost-effective use of its Training Division's expertise to strengthen these partners. CEDPA should consider whether the

sustainability of its training partners should be part of a new strategic emphasis in the area of entrepreneurial activities. If CEDPA decides to move in this direction, training institutes should be supported in developing their own marketing and management skills so that they generate income and diversify their funding base, in part by marketing to and charging the for-profit sector for their services. (p. 26)

11. Given the importance of institutional strengthening in the CEDPA model, CEDPA and ACCESS should establish procedures to assess the impact and effectiveness of their training and technical assistance and its relation to program outcomes. The project development protocols and subproject management and evaluation tools should be used consistently by ACCESS and project staff for ongoing facilitative monitoring and planning. (p. 26)

### **Family Planning**

12. As a high priority, to reduce the risk of early and unplanned pregnancy and parenthood and exposure to sexually transmitted diseases (STDs) and HIV, over the next 5-10 years, ACCESS should focus on 13 to 18-year-old boys and girls by seeking opportunities to integrate reproductive health and family planning education and gender sensitivity training for this group into ongoing programs. (p. 40)
13. ACCESS should continue to work to improve quality of care and use method continuation rates as an important indicator of service quality. Specifically, ACCESS should establish procedures to examine method continuation rates on a regular basis, with regular and frequent assessments of the most effective ways to encourage method continuation. As planned, they should also conduct client satisfaction surveys as part of their internal monitoring procedures and work to improve the quality of dropout data. ACCESS should continue to identify other service processes (for example, clinic waiting time) that reflect quality service delivery and establish appropriate measurement procedures. (p. 40)
14. As a high priority, ACCESS should accelerate its efforts to reach men with family planning education and other services. (p. 40)
15. USAID should examine the replica of the ACCESS Bihar Dairy Cooperatives subproject currently being implemented in Uttar Pradesh with a view toward expansion and replication in the state. USAID and CEDPA should also examine the lessons from Bihar Dairy Cooperative and Gujarat Trust subprojects and apply them as appropriate in Uttar Pradesh. (p. 41)



## **Reproductive Health**

16. ACCESS should continue to integrate STD/HIV initiatives into all of its projects with accelerated efforts in high risk countries. The STD/HIV initiative in India should be accelerated. Reproductive health, however, was not part of the original ACCESS design. ACCESS is developing indicators for STD/HIV in each subproject. In the next phase of the project, the ACCESS mandate, mission, and strategy should be broadened to acknowledge reproductive health objectives. ACCESS should continue to develop and monitor corresponding indicators that reflect the types and quality of services in each subproject. (p. 43)
17. Although subprojects are under pressure to move into secondary and curative care, CEDPA projects should stay focused on primary care (prevention of illness and the promotion of healthy behavior through education). Where referral and backup is needed, CEDPA should continue to find partner organizations and institutions with clinical expertise that can undertake those services. CEDPA should not move into general health care. ACCESS needs a clear policy statement on the level of clinical services it is prepared to support, taking into consideration that the Family Life and Promotion and Services (FLPS) and Kabiro-Kawangware subprojects are using the diagnosis of STDs and the sale of drugs as an income generating mechanism. (p. 43)

## **Sustainability**

18. CEDPA should develop its capacity to determine the full cost of service delivery, as well as monitor cost trends in CEDPA and its subprojects. In the same vein, ACCESS should expand opportunities to link partners with local organizations or projects which can assist them in developing their entrepreneurial thinking in the context of their mission. Partners need to develop skills in accurate and actual costing of services, plans for reducing current costs and business plans for income generation activities. ACCESS should develop linkages with successful small-scale enterprise projects, including women's credit schemes, to learn lessons about small-scale enterprise cost recovery. (p. 50)
19. As a high priority, ACCESS should review the Quality Assurance Project's integrated approach to sustainability, which also involves methodologies for addressing quality and cost-effectiveness, and consider ways to collaborate with them and use their problem-solving approaches to make progress in these three areas. (p. 50)
20. CEDPA should continue to develop collaboratively with its partners' agreed upon plans for financial sustainability, as part of a strategic emphasis on entrepreneurial thinking and activities. Plans for and education about financial sustainability should be included in the design stage of all subprojects. ACCESS is urged to support studies on willingness to pay in the countries in which it works

or use secondary data on the topic if the data are relevant and of high quality. Fees should be instituted as early in the life of a project as possible. (p. 51)

21. CEDPA should continue to diversify its funding base to ensure sustainability of its partnership activities given the uncertainty of USAID's funding and outcomes of mission planning exercises. (p. 51)
22. Now that a sustainability conceptual framework has been drafted, the ACCESS team has the opportunity to refine it at the October Planning Meeting. The stages and steps of the conceptual framework need to be linked to proven technical assistance, training and management systems. All staff and consultants need to use the framework and tools in supporting their organizations toward sustainability. ACCESS should continue to examine and test approaches to enhance the sustainability of the CBD worker, and consider including this idea in the conceptual framework. (p. 51)
23. The long-term sustainability strategy of State Innovations in Family Planning Services Agency (SIFPSA) and the organizations it is developing, as well as the constraints that inhibit CA inputs to SIFPSA, need to be clarified as part of the Management Review of the Innovations in Family Planning Services (IFPS) Project. (p. 51)

## **Collaboration**

24. ACCESS field offices should continue to provide leadership in interagency collaboration and in-country learning networks, including those that provide clinical backup. Through such networks they could share their IEC and training materials, management systems, and service delivery experience as well as learn from the experience of other NGOs and CAs. (p. 54)

## **Organization, Management, and Finance**

25. ACCESS should nationalize its field offices as soon as suitable local candidates are located and trained. The exception is India, where it may be necessary to keep expatriate staff for a few more years due to the current need for continuity during implementation in a challenging environment. This should be part of the strategic plan to make CEDPA regional offices and give them the support they need to develop new projects and leverage funds from other donors. The ACCESS International Conference in October 1995 should address the issues of regionalization and the role of the national offices. (p. 57)
26. ACCESS produces a large volume of documentation, more than USAID can read, and the project needs to find ways to highlight the most important parts of documents it sends to USAID. This could be done by flagging certain pages or preparing a two- to three-page literature review of all the documents sent during

each quarter. Each quarterly report to USAID should address at least one substantive issue with lessons learned, in addition to service statistics. The report should be reformatted to reflect the reinvention and results orientation of USAID and aim to report regularly on improvement activities and results. (p. 59)

27. Over the next two years, CEDPA should consider a major review of the responsibilities of its Washington staff to allow individuals to become responsible for processes rather than geographic regions. This would mean units for sustainability, reproductive health, quality of care, monitoring and evaluation, empowerment, and youth, perhaps using a matrix responsibility chart. This would allow for better integration of programs and, as field offices take on more backstopping responsibility, Washington staff could focus on developing models and systems in each area. (p. 59)

### **Strategic Planning and Monitoring and Evaluation**

28. CEDPA should prepare a new strategic plan that shows how all CEDPA activities are integrated at the field level, including the Better Life Education project, ACCESS subprojects and training. The new plan should address the issues of regionalization, the role of curative health care and clinic services, the activities and direction of regional training institutes, and whether CEDPA wishes to develop the India model in other countries. (p. 59)
29. ACCESS should prepare a performance monitoring and evaluation plan that is closely linked to the ACCESS strategic plan. Whatever studies are undertaken should reflect strategic objectives and related outcomes. The plan should specify the ways that monitoring and evaluation will be used to assess achievement of objectives *with appropriate indicators* that are specific, measurable, area specific, reasonable, and time bound (SMART) and develop a system for monitoring achievements toward those objectives. ACCESS should continue its current thoughtful efforts to identify indicators to assess objectives related to empowerment, reproductive health services delivery, quality of care, and sustainability, and also aim at ensuring that the indicators reflect specific strategic objectives. Cost and efficiency information should be gathered regularly through monitoring and evaluation. (p. 62)
30. To ensure managers' and donor confidence in the accuracy of outcome and other data, ACCESS should undertake an in-depth review in the field of select subprojects to examine the accuracy of service statistics. Since procedures for regularly examining data quality and retraining data gatherers as necessary are already in place, ACCESS should document procedures related to assessing and improving data accuracy and periodically discuss these procedures in semi-annual reports. (p. 63)

# 1. Introduction and Background

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Founded in 1975, the Centre for Development and Population Activities (CEDPA) is a registered private voluntary organization with a mission *to empower women at all levels of society to be full partners in development*. As a minority firm it qualifies for special recognition under the Gray Amendment to the Foreign Assistance Act. CEDPA is an international organization and had an operating budget of US\$10.5 million in 1995.

CEDPA has a global network of individuals and organizations committed to women's health and empowerment, social and economic development, and democracy building. CEDPA works in partnership with a network of women and men who are alumni of CEDPA's Women in Management (WIM) training and Institution Building (IB) workshops in Washington and regional training programs. The organization represents approximately 900 nongovernmental organizations (NGOs) and public sector institutions in 105 countries around the world.

To fulfill its mission of women's empowerment, CEDPA's core strategies are management and leadership development, institutional capacity building, community-based programs, and advocacy. In 1995, CEDPA is implementing its development strategies and programs in the field through grants to 41 local NGO partners. Its major activities are the CEDPA ACCESS to Family Planning Through Women Managers Project (ACCESS), a Romania project in family planning service delivery, the Better Life Options for Young Girls and Women Project, and the Partnership Projects for Girls and Young Women in Egypt.

## 1.1 Previous Project

In 1985, the United States Agency for International Development (USAID) awarded CEDPA a six-year, US\$8.1 million Cooperative Agreement entitled "Expanding Family Planning Service through Third World Women Managers." The purpose of that project was to increase underserved women's access to family planning services and increase women's participation in the development and delivery of services. Its success has been attributed, to a large extent, to those alumni whose leadership and community involvement enabled CEDPA to reach 112,000 new acceptors and provide 87,000 couple years of protection (CYP) as of June 30, 1990. The ACCESS project was designed to build on the experiences of this earlier project.

## 1.2 The ACCESS Project

The CEDPA/ACCESS project was launched in 1991, through a Cooperative Agreement from the USAID Office of Population. In 1994, USAID raised the Cooperative Agreement ceiling from US\$15.6 million to US\$27 million, and extended the project for one year from August 1996 until August 1997.

Shortly after the amendment to extend the project and increase the funding ceiling was granted, USAID Mission interest in CEDPA increased and a new budgeting system was instituted which obligates project funds through field support. Field support funds count toward the core ceiling. The total Fiscal Year (FY) 1995 obligation for ACCESS is US\$7.79 million, up from US\$4.5 million in FY 1994. Consequently, the ACCESS project will reach its total funding ceiling in FY 1996. The Office of Population has decided to increase the ceiling to approximately US\$40 million to support the project until August 1997.

The goal of the ACCESS project is to improve the health and well-being of women through family planning. The project is intended to lower fertility through increased access to quality family planning services and to help ensure that unmet demand for these services is addressed through provision of appropriate financial, technical, and human resources. Project objectives are specified in Chapter 2.0, Achievement of Objectives.

USAID conducted management reviews of the ACCESS project in 1993 and 1994. The 1993 review concluded that ACCESS's service delivery should be expanded and improved through strategies such as: 1) advocacy and coalition building to promote policy changes and remove barriers, 2) grassroots mobilization and development of community networks, 3) raising of gender awareness, 4) improved and expanded training, 5) development of new service delivery models, and 6) integration of AIDS and sexually transmitted disease (STD) prevention strategies into projects.

The USAID 1994 ACCESS management review noted that the project should: 1) continue to provide critical technical assistance to field projects and regional and country offices, 2) ensure that systems are in place for all integrated services to document project effects on family planning and communities, and 3) explore opportunities to diversify their funding base for the population projects.

As technical demands were rapidly increasing, the 1994 review also suggested that ACCESS should increase both headquarters and field staff and continue collaboration with other Cooperating Agencies (CAs). Program approaches would include expanding male involvement in family planning, activities with youth, building on the Better Life Options for Girls and Young Women Project, service delivery in new countries, and the addition of more barrier methods to programs.

### **1.3 Evaluation Methodology**

This evaluation of CEDPA's ACCESS project was undertaken by the Population Technical Assistance Project (POPTech) for USAID/G/PHN/POP from July 31 to August 31, 1995. The purpose of the evaluation was to address the following USAID questions, among others:

- To what extent has the project accomplished the purpose set out in the project agreement?

- What models and strategies does ACCESS use to accomplish its objectives?
- To what extent has CEDPA empowered the women whom it has trained?
- How have the organization, management, and finances of the ACCESS project influenced its accomplishments and capacity for future expansion?
- How, and to what extent, has the project provided quality family planning to women, particularly young, low-parity women?
- To what extent are local organizations more sustainable, especially institutionally sustainable, as a result of receiving support from ACCESS?
- What needs or issues not dealt with in the project should be addressed in a follow-on project?

The complete Scope of Work is attached as Appendix A.

The evaluation team included Ms. Maureen Norton as team leader. Ms. Norton is a Senior Policy Analyst with Research Triangle Institute and was the Chief of the Evaluation Division in the Asia Near East Bureau for eight years. Ms. Waneen Polly is a consultant who has designed and managed family planning and other nongovernmental organization projects in West Africa and the Pacific. She was a Peace Corps director in Papua New Guinea. Dr. Shirley Buzzard is a consultant with experience with NGOs worldwide and she also headed the team that evaluated CEDPA's previous Cooperative Agreement with USAID.

The evaluation schedule began with a week in Washington for a two-day team planning meeting, interviews, briefings by USAID/G/PHN/POP and CEDPA. The team then spent five days in Kenya, five days in India, and returned to Washington, D.C., for eight days of follow-up interviews, debriefings, and report writing.

Sources of data for the evaluation included an extensive collection of project documents prepared by CEDPA and interviews in Washington. Faxes were received from the Kenya, India, Nepal, and Nigeria USAID Missions and telephone interviews were held with CEDPA staff and USAID Mission staff in Nepal, Tanzania, Nigeria, Mali, and Egypt. In the field, the team visited all four active projects in Kenya and three projects in India. In India the team also met with Prerana, the ACCESS sponsored training organization. The team developed interview protocols that were used for interviews and group meetings. In each country, the team interviewed project staff, USAID Mission PHN officers, others knowledgeable about CEDPA's work (such as other CAs and NGOs), and CEDPA alumni. In total, the team conducted over 120 interviews, held 10 group interviews with community-based distribution (CBD) workers and clients, including interviews with 22 alumni of CEDPA's WIM training.

With field visits, project documentation, and telephone calls to the field, the team had access to ample information on all projects in Africa (Kenya, Mali, Nigeria, Tanzania,) and Asia (India and Nepal). The Middle East projects (Egypt and Turkey) closed in 1993 due to USAID policy changes.

ACCESS project staff were very well prepared for the evaluation and provided the team with extensive documentation of their work as well as several briefing books. The main

weakness in the evaluation methodology was that the team did not have adequate time to review all the documents at the level they deserved.

## 2. Achievement of Objectives

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Over the years, USAID has stressed the importance of several fundamental objectives. These include: achieving a demonstrable impact on people, empowering women and other disadvantaged groups, enhancing the participation of partners, managing for results, and gathering qualitative and quantitative data to monitor performance, guide management decision making and document achievements and results. CEDPA/ACCESS has accomplishments in all of these areas. Its institutional and organizational progress over the past five years have been impressive.

The key project objectives (1991-1997) as amended in FY 1994 are to

- a. expand quality and cost-effective service delivery, and promote more effective methods
- b. enhance women's participation in family planning
- c. strengthen the capacity of institutions to support sustainable family planning services
- d. cluster subprojects strategically in the three regions of Africa, Near East, and Asia
- e. develop field resources to support subprojects
- f. provide short-term technical assistance to develop and strengthen family planning programs
- g. provide expertise in planning, management, training, program design, implementation, and evaluation

As shown in Table 4, Key Accomplishments, 1991-1994, ACCESS has met or exceeded all but one of the objectives set forth in the amended project design. The planned Consultant Corps objective of training 75-100 individuals was not achieved due to problems in the design. As follow-up, plans have been developed to revise the training and to train an additional 40-50 alumni over the next 18 months. The Nigeria program, however, trained over 50 master trainers to serve as trainers for other subprojects. The table, however, focuses on the achievement of quantitative objectives. As such, it fails to capture the diversity of ACCESS subprojects, as well as the thoughtful conceptual framework which guides subproject design and implementation. This conceptual framework reflects CEDPA's holistic approach to sustainable development and provides a means for integrating the concepts of women's empowerment, participation, and institutional strengthening into subproject activities at the community-level. Focusing merely on quantitative achievements also fails to convey ACCESS's considerable implementation and evaluation experience, as documented by the project's wide-ranging internal evaluation and other literature produced over the years. (See Appendix M - Bibliography.)

Although 33 subprojects to date have been funded under the ACCESS project, a total of 20 subprojects are currently funded, including those in Nigeria and Tanzania. This is in part due to changes in USAID priorities. Information from discontinued projects suggests that all are continuing at some level without ACCESS funding. More will be said about sustainability in Section 2.1.6.



Insert Table 4

All USAID Missions that the team interviewed gave the ACCESS project high marks for its management excellence, flexibility, and responsiveness. (See Box 2 - USAID Missions' Views of ACCESS.) The sole concern, which was expressed by the Kenya and Nepal Missions, was about the pace of decentralization. This concern has now been addressed.

Overall, the evaluation findings are positive. As in any project, there are areas of greater and lesser accomplishment and some implementation difficulties. Nevertheless, the evaluation team focused on the progress made since the last evaluation. CEDPA has followed up on the recommendations of the last evaluation and has made noteworthy progress in management and financial systems, monitoring and evaluation, quality of care, integration of reproductive health systems, and institutional and financial sustainability.

## **2.1 Overview of the CEDPA Model for Sustainable Development**

CEDPA has developed an approach to development that features a synergistic interaction between training, long-term partnerships, empowerment, and technical assistance. The model functions simultaneously at the level of the individual woman and of the nongovernmental organization or community group of which she is a part.

The model involves

- the simultaneous development of individuals and institutions
- an emphasis on the empowerment of women
- long-term, reciprocal partnerships between individuals and organizations
- a commitment to management excellence and participatory management that aims at creating quality family planning services for women and sustainable organizations headed by women
- an effort to ensure replicability—strategies based on the model are being replicated in both Kenya and India

Key features of the model are

- partnership, with an emphasis on participation (by the community and by the individual in reproductive health decisions)
- empowerment
- institutional strengthening

At the individual level, the process usually begins with attendance at CEDPA's five-week WIM training or IB workshops held each summer in Washington, D.C. At these workshops, participants meet women from many other countries and attendees often

## Box 2

### USAID Missions' Views of ACCESS

Comments from USAID Missions:

*"In addition to the specific outputs or achievements of CEDPA's activities over the past two years, the process through which this was accomplished is a key to the overall program success." -- USAID/Nigeria*

*"One of the noteworthy achievements to date with the [subprojects] is that [they] have taken steps to bring more women staff into the family planning programs and both have hired women at the headquarters level to manage their project training activities...CEDPA/ACCESS's work in Nepal is a critical component of the Mission's stated objective to reduce fertility through increasing the use of quality family planning services." -- USAID/Nepal*

*"CEDPA/ACCESS's activities can and are being replicated in other parts of the country. One of the key accomplishments of the ACCESS project was the replication and expansion of an urban slum project in Gujarat and a dairy cooperative project of Bihar as CBD projects in Uttar Pradesh." -- USAID/India*

*"CEDPA/ACCESS has been able to effectively work with difficult-to-reach groups (e.g. slum dwellers, commercial sex workers, and rural women)... These projects are unique in that they are managed by CEDPA alumni and involve integrated service delivery with organized women's groups, small business enterprises, and slum communities." -- USAID/Kenya*

*"Having regional ACCESS staff is important to us, someone who knows the local culture and language. Although our projects are just a couple of months old, everyone feels very positive about CEDPA." -- USAID/Tanzania*

report that the course is a life-changing experience. Women return to their communities with a sense of empowerment, solidarity with other women, and skills to accomplish tasks. On her return, the woman becomes a member of the CEDPA alumni network which operates informally in each country. Alumni form "old girl" networks for the exchange of information and collaboration. Although the training is targeted at mid-level managers, many women later become senior-level managers. (See Section 2.1.1 for more on the effect of WIM training on the empowerment of women.)

While the individual is empowered and trained, a simultaneous process is going on at the institutional level. Subprojects are carefully selected, and they are often grassroots projects headed by women. If alumni are not already involved, staff may be sent for WIM training or IB workshops. Each subproject is provided with a package of technical assistance, training, and hands-on support as it evolves towards sustainability and independence from CEDPA. The training and technical assistance is in both management (management information systems, financial systems, office procedures) and project development (project design and evaluation, CBD training, quality of care, and reproductive health).

Through ACCESS, institutions receive funds, technical assistance, and training to support service delivery. ACCESS service delivery aims to help women participate in decisions that affect their lives by giving them an informed choice concerning family planning methods, access to the methods of choice, and information to make decisions about their own reproductive health. The ACCESS project has evolved over the past five years to include family planning services and a package of reproductive health services for women such as the diagnosis and treatment of sexually transmitted diseases and HIV/AIDS.

The key features of the CEDPA model are presented in Figure 1 which appears in the Executive Summary.

### *2.1.1 The Empowerment of Women*

#### **To what extent has CEDPA empowered the women that it has trained?**

CEDPA views empowerment as more than an abstract theoretical concept. In Africa, for example, given the spread of AIDS and the fact that many African men have on average three to four partners at any one time, empowering women with information that allows them to take control of their sexuality is more than a moral imperative. It is a matter of life and death. Thus, both theoretically and operationally, empowerment is an integral element of CEDPA's work.

CEDPA defines empowerment as the process by which a woman becomes aware of her abilities and identity and actively seeks to bring about positive change for herself, her family, and her community. CEDPA/ACCESS has developed four primary strategies for empowering women:

- employment of female workers
- advocacy and leadership development
- training
- service delivery

CEDPA's efforts to integrate women's empowerment into their field efforts, especially through training, may give CEDPA a unique comparative advantage. Studies of girls' and women's education have shown important linkages to improved economic and social outcomes. In the World Development Report 1993, girls' primary education was ranked as a highly cost-effective intervention leading to improved health outcomes, increased likelihood of adopting and continuing family planning methods, and raising the family's economic well-being. Numerous studies of female education have demonstrated the link between educational status and family health, contraceptive usage, and social well-being, and thereby leading to the economic productivity of family members. A 1995 World Bank report concluded that investing in the training and education of women is not merely a moral choice, but a wise economic investment as well. It has been demonstrated that women's contribution to the economic well-being of the family is greatly under-represented in the formally collected economic statistics of most developing countries. Efforts to study how women's empowerment programs and group training efforts affect health status, family planning adoption, and economic productivity are only now becoming available, and such studies face measurement problems similar to those which lead to under-representation of women's output in national income statistics.

### Accomplishments

Four thousand women and men have attended WIM and IB workshops in Washington and in different regions over the past 20 years. The ACCESS project has supported 32 women managers at the WIM courses and an additional 16 managers to the Institution Building workshops in Washington. CEDPA has developed a distinctive, highly participatory style that workshop participants find innovative and informative. Several alumni said that they thought they knew what participation was until they attended a CEDPA workshop, and now they have changed their entire management style to be less dictatorial. Regional WIM trainings are scheduled for both Kenya and India later this year.

The unique aspect of CEDPA's development model is the long-term relationship the organization maintains with the women within its network. Many women who attended WIM programs 15 years ago are still actively involved with CEDPA. CEDPA supports WIM alumni through training, technical advice, and opportunities. They give back to CEDPA through supporting other alumni, providing technical assistance and training to ACCESS subprojects, and participating in evaluations, workshops, and other events.

A key question is, to what extent have CEDPA empowerment strategies contributed to positive program outcomes? While CEDPA has yet to undertake comprehensive studies to answer this question, CEDPA's strategies have contributed to important changes in women's lives. Some of these outcomes are as follows:

Employment of Women Community Workers. At the community level, women who had never held jobs and who rarely left their homes are now trained as CBD workers. At least 2,773 women have been trained as community outreach workers. CEDPA research on perceived changes in CBD workers' lives in seven countries found that they were able to bring about improvements in the workers' lives. Not only were there changes in their economic status, knowledge, and skills, but a majority perceived better relations with their families and increased decision making within their household (Kak and Narasimhan, 1992). These two researchers who conducted group interviews with CBD workers confirm that this training and responsibility has a positive effect on women, including pride in their work, greater self-confidence, improved relations with their husbands, and increased respect from the community.

In Nepal, family planning programs have customarily not included women, many of whom are non-literate and rarely travel away from home. The ACCESS project supported subprojects that trained women as field-workers and trained male supervisors in gender issues. By attending literacy classes and providing a much needed service, women CBD workers have gained higher esteem and report greater control over their life. (See Box 3 - Comments of CEDPA Alumni on WIM Training.)

CEDPA Training. At the managerial level, ACCESS reports that it trained 82 women as CBD supervisors, 76 women in subproject management, and 54 in administrative support.

CEDPA's WIM and other Washington-based workshops target mid- and senior-level managers. Over time, many of the alumni have moved into very senior positions in their own organization and government. CEDPA boasts among its alumni, three members of parliament in Kenya, the Vice President of Uganda, and the Chair of the Public Service Commission in Kenya. The alumni almost always move on to higher positions, continue to work on women's issues, and continue to serve in public service jobs. In Kenya, a CEDPA WIM alumni is the Chair of *Maendeleo Ya Wanawake*, a grassroots organization that includes nearly all rural women in Kenya.

WIM participants often come from family planning programs, but women from all backgrounds are represented. Alumni, inspired by the workshop and equipped with better management skills, start or expand existing projects that provide family planning services to women. Alumni attend other workshops in Washington (the Supervision and Evaluation workshop or the Institution Building workshop) or in-country training given by CEDPA/Washington's training unit. As CEDPA's activities in-country take hold, more training is done by alumni. CEDPA/Washington also occasionally pays for alumni to attend workshops, conferences, and study tours in other countries.

At the community level, one of ACCESS's greatest successes has been in training women in Egypt. There ACCESS trained governors' wives of the Upper Egypt governorates and their local women's councils. Although before the training the women deferred to men and rarely spoke up, after training they reportedly began to take an active role in council deliberations and began to speak out on women's interests, especially, in the area of reproductive health. This is an experience ACCESS might

### Box 3

#### Comments of CEDPA Alumni on WIM Training

Over the course of the evaluation, the team interviewed 22 WIM alumni, including one woman who attended the first WIM in 1978. The team only heard positive comments, such as the following:

*"The main skill I got was proposal writing -- It was my second trip to the U.S."*

*"I regard CEDPA as my family. They empowered me and always support me."*

*"It's not just a training, its a whole experience."*

*"It made me a lot nicer. I used to think I knew what was best for others but after the training I have much greater appreciation for what community women think."*

*"CEDPA's strength is in its follow-up. It has helped us become leaders, the challenge now is to help us become better leaders."*

*"The issues are different for Africa and Asia and yet they are basically the same. It was very helpful to me to meet other women working on the same issues. I learned proposal development, monitoring and evaluation, but mostly I learned a style of training. I got leadership skills, assertiveness, and a lot of self-confidence from the WIM."*

*"It was the experience of a lifetime. I just wish I had it ten years earlier. I've been doing training all my life and this was the first time I had seen training planned around modules and with careful timing. It was so participatory they don't really teach, they just draw things out of you. I didn't really understand participation. That was the first time I knew I was empowered."*

*"WIM changed my perception of management. I learned about feedback, delegation, motivation, and proposal development. It was very interesting to meet women from other countries and see the commonalities."*

consider duplicating in India for newly elected *Panchayat* (community council) members and in other countries with emerging democracies.

CEDPA Advocacy and Leadership Development. In addition to the empowerment of individual women, CEDPA has taken the lead in policy change through its work on the International Conference on Population and Development (ICPD) in Cairo in September 1994. Through adding funds to the ACCESS project, a Leadership Education and Advocacy Project (LEAP) was undertaken that involved a series of activities leading up to the Cairo Conference. LEAP's objectives were to prepare women for the ICPD conference in Cairo, support their participation in official delegations, and train women in leadership, advocacy, and communication skills. Starting with a delegation of 31 people from 17 countries, CEDPA attended PrepCom II in New York in May 1993 and ended with a delegation of 62 women at the conference in Cairo.

The African alumni were particularly active at the ICPD in Cairo. The Kenyan alumni took an active role in shaping that country's contribution to the conference. At the ICPD, with other alumni, they organized the African Women's Caucus (AWC) which helped to persuade their countries to support the ICPD plan of action. The AWC has been asked to participate in the 1995 World Conference on Women in Beijing.

Following the ICPD, CEDPA conducted strategic planning meetings with ACCESS subproject managers to help develop CEDPA's post-Cairo plan of action. In interviews with women who attended the ICPD, they speak of the profound effect the conference had on their lives, particularly, those who feel that their views were incorporated into the conference planning and deliberations.

As a result of CEDPA's participation in the conference, they published a book called Cairo, Beijing, and Beyond: A Handbook on Advocacy for Women Leaders. Under its United Nations Population Fund (UNFPA) grant, CEDPA's Training Division has developed and is field testing a training program using CEDPA's distinctive, highly participatory training style. The Training Division is also presenting their first three-week advocacy workshop this year.

Measuring women's empowerment is difficult and subjective, but in Nigeria ACCESS subprojects have worked closely with the USAID Mission on its mandate of empowering women. Broadening its focus from family planning service delivery to reproductive health care and informed choice, ACCESS has worked with subprojects to develop indicators of women's ability to make decisions affecting their own health and that of their families. These indicators are presented in Table 5. These indicators are a good start on monitoring empowerment but the challenge will be in finding simple methods for gathering data on each indicator.

### Concerns

- The planned training of 75-100 alumni to become consultants does not seem to have developed as planned. Two training sessions were held, one in Kenya and another in India. Thirty-two alumni were trained. The objectives were overly



Insert Table 5

optimistic and the participants all had full-time positions elsewhere. Therefore, they were not in a position to carry out the objectives and activities as planned. The very successful training program in Nigeria and Training of Trainers (TOT) workshops, however, provided a successful model upon which the Alumni Consultant Corps can be redesigned. In the next 18 months, additional training workshops will be held for selected alumni so that CEDPA and ACCESS can tap into their expertise in appropriate ways for training and technical assistance.

- The alumni networks exist informally but could be motivated and mobilized in more strategic ways. In Kenya, the informal alumni group has developed a strategic plan but lacks financial and institutional support to carry it out. During the evaluation team's group meeting with approximately 20 Kenyan alumni, they identified a range of specific activities they wish to work on, but lack of support to date has impeded their ability to move forward. Geographic distances in India make an Indian alumni network difficult to sustain, but they could be a much greater resource than they currently are.
- CEDPA has always targeted mid- and senior-level women for its training, but the network does not include young women.
- CEDPA's Better Life Education (BLE) project is a natural tie-in to its subprojects. While BLE programs operate in the same countries as the ACCESS projects, they are not in the same communities.

## **Recommendations**

5. To reduce the risk of early and unplanned pregnancy, ACCESS should include in its empowerment activities a focus on young girls and boys, 13-18 years of age, by (a) developing reproductive health, self-esteem and skills building courses for this group; and (b) implementing alumni mentoring activities which support young women.
6. Using simple data collection methods, ACCESS should test the indicators of empowerment of women in Nigeria that it developed with the International Center for Research on Women (ICRW) in other projects. ACCESS should continue to examine the extent to which empowerment strategies affect program outcomes and consider including these topics in the strategic plan. Important questions are: do empowerment strategies affect program outcomes? Do they result in "better" program outcomes than more traditional service delivery strategies?
7. CEDPA needs to develop ways to track WIM participants over time to monitor their empowerment, and their effect on women in their country as they move up in their career. While the anecdotal information on WIM participants is impressive, it could be systematized.

8. As women can only advance as men's perceptions of them change, CEDPA's Training Division needs to undertake extensive Training of Trainers (TOT) on gender sensitivity for men at all levels, from senior government officials down to school boys. ACCESS should develop some short, simple activities that CBD workers could include in their information, education, and communication (IEC) efforts.
9. In India, elections were recently held for *Panchayat* (community council) members, and by law, one-third of council members are women. Very few of these women have any leadership training, and most are seen as fronts for their husbands. Building on CEDPA's very successful experience of training women in Egypt, CEDPA (with assistance from USAID/India) should discuss with this group whether CEDPA training in leadership, assertiveness, and management would be desired.

### *2.1.2 Technical Assistance, Training, and Institutional Strengthening*

#### **What impact has ACCESS Technical Assistance (TA) had on the development and strengthening of family planning programs, service delivery, and access?**

##### Accomplishments

Two key features of the CEDPA model of development, the simultaneous development of the individual and the institution, are successfully demonstrated by the ACCESS project. Each ACCESS subproject is provided with a package of technical assistance, training, and hands-on support as it evolves toward sustainability and independence from CEDPA. A review of current project files showed that project agreements outline a work plan which is revised yearly and reported quarterly.

USAID Missions reported satisfaction with the technical assistance and training provided. *"CEDPA is able to put in the right technical assistance, the right money, at the right time to get the desired results,"* commented USAID/Mali on ACCESS's success in spinning off the Katibougou Family Health Project into an independent NGO in 18 months.

Technical Assistance. Technical assistance provided by the ACCESS project has been timely, of good quality, and has resulted in the improvement of access and quality of service. Since 1991 the ACCESS project has provided 7,215 days of technical assistance, 54 percent to subprojects in Africa, 30.2 percent to Asia and 6.1 percent in the Near East. The majority of the support has been in program support (local and regional TA 27.9 percent; international TA 14.7 percent), new program development (20.2 percent), documentation (18.1 percent), financial management (9.2 percent) and training (6.8 percent). (See Appendix C - Total Days of ACCESS Technical Assistance by Function.) For program technical assistance, twice as many support days (2,013 days) have been provided by local and regional consultants and staff than by international consultants (1,064 days). For program development, 55 percent of the

support days were provided by local or regional TA. (See Appendix D - ACCESS Technical Assistance.)

- In Uganda - the ACCESS project provided in depth technical support to the Young Women's Christian Association (YWCA) to establish a new delivery system—the first in the nation to focus on youth, through a non-traditional provider. Two clinics were established and 103 field-workers were trained to provide family planning and reproductive health services.
- In Kenya - ACCESS took over the Kabiro Kawangware Community Health project, which had fallen into disarray, despite many years of support from other organizations. WIM training was provided for the project manager, CBDs attended refresher courses, and regional ACCESS staff provided consistent support in creating effective service delivery systems. With 83 percent of the subproject completed in 1995, ACCESS had achieved 355 percent of the total planned number of new clients.
- In Nigeria - ACCESS/Washington provided leadership in designing and establishing the program under very difficult circumstances. Four alumni consultants participated in the design of 10 new subprojects for reproductive health services. Technical assistance was provided in training 50 master trainers who in turn trained 1,200 CBDs. In eight months 90 local affiliates had 36,000 family planning clients. Assistance in project design from local consultants resulted in culturally appropriate, well-utilized, and accessible services. (Appendix E - Maximizing Impact through Training of Trainers in Nigeria)
- In India - ACCESS has provided a range of technical assistance to the State Innovations in Family Planning Services Agency (SIFPSA). ACCESS contracted with Tata Consultancy Services to develop management, personnel, and financial systems for SIFPSA. In addition, ACCESS has overseen the development of SIFPSA's Management and information system (MIS), supported staff recruitment efforts, and completed a resource library system. USAID/India staff state that, while this is a slow process, ACCESS staff have made great strides in one year.

Institutional Strengthening. ACCESS has been successful in establishing solid management and financial systems in its subprojects. An array of tools and models to assist partners in project development and management have been developed. (See Box 4 - Management Tools.)

## Box 4

### ACCESS Management Tools

Financial Management for Projects Manual, 1993

Project Development Notebook–Procedures and Protocols, 1995

Framework, Activities, and Tools; Evaluation Division, 1995, which includes

Start-up Management Assessment Tools

Subproject Monitoring Tools

Quality of Care Assessment Tool and Action Plan Format

MIS Record Keeping and Reporting Forms

Partners are trained in the use of the tools and follow-up technical assistance is provided to assure the successful implementation of the systems. Project staff have demonstrated skills in using the MIS and financial data to identify problems and implement corrective action. Evidence of success includes meeting project objectives within budget as reported in Chapter 2.0.

The project development process has been evolving over the life of the ACCESS project. In Tanzania ACCESS used the newly published Project Development Protocol to identify a viable partner organization and to develop the requirements for technical assistance and training. USAID/Tanzania has expressed satisfaction with the process and results, especially, the use of regional technical experts who were fluent in the local language and sensitive to cultural issues.

Providing training and customized technical assistance in financial management to the subprojects has resulted in timely, accurate financial reporting by subproject accountants and successful yearly audits. In Kenya, by decentralizing, local accountants are able to assure timely disbursements to subprojects, monitor subproject financial status through quarterly financial reports, provide technical assistance, and participate in start-up activities to launch subproject financial systems successfully.

In reviewing subproject capacity to carry out financial and administrative functions, ACCESS has supported the employment of subproject accountants, the computerization of financial and MIS systems, and the training of subproject staff in computer skills to assure that the expertise keeps pace with the growth of the organization. Monitoring and use of MIS are discussed further in Section 3.3.

Training. The ACCESS project has a four tier approach to institutional and human resource development through training. The decentralized approach strengthens in-

country capacity to carry out training, either through training institutions or local consultant trainers, relevant to the institutional sustainability of partner organizations. The tiers are

1. Washington Training Programs - Project managers and staff participate in the highly rated CEDPA WIM, Supervision and Evaluation (S&E), and Institution Building training programs.
2. Regional Training Programs - Project managers and staff from ACCESS partner projects and the community attend workshops conducted by Washington-based and regional trainers. The goal is to introduce new or enhanced approaches and encourage cross-fertilization among regional projects. Regional trainings have included MIS (1993/1995), Quality of Care (1994/1995), IEC (1995), and Strategic Planning for Sustainability (1995). (See Appendix F - Regional Workshops.)
3. In-Country Training Programs - Training is usually conducted by local consultants or through local training institutes which have been trained by CEDPA/ACCESS. A total of over 8,000 service providers and project managers have been trained since 1991.
4. Individual Training - ACCESS has supported 73 women and 13 men from ACCESS subprojects or associates to attend 35 programs relevant to the development of the institution they represent. (See Appendix G - Institution Building.)

The in-country training programs demonstrate the working of the ACCESS model at the field level, including the commitment to upgrading technical skills through yearly refresher courses and expanding skills to address community identified needs such as STD/AIDS integration. (See Appendix H - Subproject Training Activities.) A summary of four subprojects and nine technically supported training activities follows in Box 5.

Through ACCESS technical assistance the capacity of organizations in six countries has developed and/or been strengthened to provide reproductive health technical training, project design, and project management training to local and/or regional organizations. Four of these are training institutes: Prerana Population Resource Center (PPRC) in Uttar Pradesh, India; the Nepal Country Office; the Institute for Training and Research in Family Planning in Egypt; and the Pakistan Voluntary Organization for Health and Nutrition. (See Box 6 - Training Institutions Developed by CEDPA/ACCESS.)

Organizations who are partners with ACCESS and who carry out training functions are *Association de Soutien au Developpement des Activites de Population* (ASDAP), that is, the Association for Health and Population Activities in Mali and a syndicate of master trainers in Nigeria. (See Box 7 - Training Organizations.)

Box 5

### Selected Subproject Training Activities

Subproject and Total Trained	Initial Training Year/ # Trained	Refresher Year / # Trained	Depot Holders Year / # Trained	Other Training Year/ # Trained
<b>INDIA</b>				
<b>Gujarat State Crime Prevention Trust</b>  Total: 178 trained	1992 10 FW 1 FW Assistant  1994 4 FW	1992 12 FW 2 FW Assistants  1993 16 FW  1994 16 FW	1993 18 DH  1994 32 DH	QOC/AIDS  1994 18 FW 1 FW Assistant
<b>Bihar State Cooperative Milk Producers Federation</b>  Total: 438 trained	1991 51 VHW  1992 58 VHW  1993 56 VHW  1994 52 VHW	1992 13 VHW  1993 22 VHW  1994 44 VHW	1994 73 DH	Study Tour  1993 6 Supervisors  Host Uttar Pradesh Project Visit  1995 63 DCS members
<b>NEPAL</b>				
<b>Family Planning Association</b>  Total: 946 trained	1994 Basic FP STD/AIDS Training  15 Supervisors 450 CBD	1995 450 CBD		MIS 1994 15 Supervisors  Gender and Development 1994 16 Supervisors

## Selected Subproject Training Activities (Continued)

Subproject and Total Trained	Initial Training Year/ # Trained	Refresher Year / # Trained	Depot Holders Year / # Trained	Other Training Year/ # Trained
<b>NIGERIA</b>				
<b>9 NGO - TA</b>  Total: 1,205 trained	1994 50 Master Trainers  1994 155 CBD			
<b>KENYA</b>				
<b>Family Life Promotion &amp; Services</b>  Total: 439 trained	1991 60 CBD  1991 AIDS Initial Training 50 CBD  1993 Kisumu Initial Training 20 CBD 12 CBD  1994 STD/AIDS Counseling Integration - 80 CBD	1992 60 CBD  1992 AIDS Refresher 60 CBD  1993 60 CBD		Sales Record Keeping  1993 15 CBD

## LEGEND

CBD = community-based distribution	DCS = dairy cooperative societies (Bihar)
DH = depot holder (NRC trainee)	FW = field-worker
VHW = village health worker	



Box 6

**Training Institutions Developed by CEDPA/ACCESS**

<b>Training Institute</b>	<b>Country</b>	<b>Year Partnership Established</b>	<b>Training Capacity</b>
Prerana Population Resource Center	India	1994	Training and project design consultant for SIFSPA (Appendix I)
Nepal Country Office	Nepal	1988	Family planning, community participation
Institute for Training and Research in Family Planning	Egypt	1980	Family planning, STD/AIDS, gender, governors' wives advocacy
Pakistan Voluntary Organization for Health and Nutrition	Pakistan	1987	Family planning, MCH, service delivery

Box 7

**Organizations Developed by CEDPA/ACCESS Carrying Out Training Functions**

<b>Training Institute</b>	<b>Country</b>	<b>Year Partnership Established</b>	<b>Training Capacity</b>
ASDAP	Mali	1987	Conducting fee for training courses for project management and CBDs, seeks to have a regional program
Trainer of trainers (10 states)	Nigeria	1993	Family planning, HIV/AIDS advocacy

PPRC in India was initiated in 1994 with funding from ACCESS to provide technical assistance in proposal development and management and training support to NGOs in Uttar Pradesh (UP) who are carrying out SIFPSA family planning projects. PPRC, with technical assistance from ACCESS/Washington, has developed 11 training modules (family planning, management, supervision, training of CBD workers, IEC, MIS, quality of care/Contraceptive Technology Update [CTU], gender issues, commodity logistics, staff recruitment, monitoring, and financial management), trained more than 400 participants, assisted 18 NGOs with program designs, and conducted two NGO Innovations in Family Planning Services (IFPS) Orientation Workshops for 51 NGOs in Uttar Pradesh. ACCESS has also enhanced the participatory training skills of the PPRC staff through TOT and conducting training workshops together. (See Appendix H - Subproject Training Activities.)

The Nepal CEDPA office, which will soon change its name to avoid confusion with the CEDPA Field Office, has trained 509 participants through the ACCESS project and UNFPA since 1991. It will stop working as a funding agency and consolidate its functions to focus on training.

In Mali, ASDAP has begun to organize CBD training for NGOs, the Ministry of Health, and other CAs and donors. In 1994, ASDAP partnered with CEDPA's Training Division to conduct its first tuition-based Strategic Planning workshop to improve Francophone NGO capacity to deliver family planning in the private sector. ASDAP has plans for a workshop for Francophone NGOs interested in promoting adolescent reproductive health and in becoming a regional training center.

ACCESS, through the CEDPA Training Division, has developed, field tested, and published four training manuals and have four more that will be published in fall 1995 (See Box 8 - ACCESS Training Materials.) The manuals distill the experiences CEDPA has gained through 20 years of conducting practical, competency-based, participatory training. The manuals complement each other as well as the WIM and IB training. A review of the manuals showed that the themes of achieving quality management through the use of human resources and MIS information, project sustainability, and quality of care are woven throughout.

These materials are customized to address local needs in each country. Training programs consistently use the participants' own organization as a model on which to apply new skills and ACCESS staff follow up with participant organizations to facilitate the implementation of the lessons learned from the workshop. Materials are also developed at the field office level with a local trainer.

### Concerns

- The quality and effectiveness of training may be diluted over time unless there is continued commitment to upgrading technical content and the skills of local trainers.
- While project development protocols have been developed and used for project design, these and subproject management tools are not as well used in ongoing

Box 8

**ACCESS Training Materials**

Training of Trainers for Development, Vol. IB - I (1994)

Project Design for Program Managers, Vol. IB - II (1994)

Gender and Development, Vol. IB - III (English, Fall 1995)

Supervision, Vol. IB - IV (English, Fall 1995)

Integrating STDs and AIDS Services into Family Planning Programs,  
Vol. SD-1 (Draft 1995)

Training Community-Based Distribution Agents in Family Planning,  
Vol. SD-2 (Draft 1995)

Formation des formateurs par le developpement: Comment realiser  
un atelier consacre aux techniques de formation participative,  
Vol. IB - I (French, Fall 1995)

Conception de projet pour les directeurs de programme: Realisation  
d'un atelier consacree a l'organisation de project a base  
communautaire, Vol IB. - II (French, Fall 1995)

monitoring as they might be. Baselines are not always repeated and the organizational development checklist is not consistently used by subproject or ACCESS managers.

## **Recommendations**

10. Since CEDPA's training partners have the opportunity to multiply the impact of ACCESS training and technical support, these institutions need to be provided with technical assistance to sustain the quality of their work and expand their areas of expertise to include management-related training on reproductive health, community health, and gender issues. ACCESS/Washington should examine ways to ensure the most cost-effective use of its Training Division's expertise to strengthen these partners. CEDPA should consider whether the sustainability of its training partners should be part of a new strategic emphasis in the area of entrepreneurial activities. If CEDPA decides to move in this direction, training institutes should be supported in developing their own marketing and management skills so that they generate income and diversify their funding base, in part by marketing to and charging the for-profit sector for their services.
11. Given the importance of institutional strengthening in the CEDPA model, CEDPA and ACCESS should establish procedures to assess the impact and effectiveness of their training and technical assistance and its relation to program outcomes. The project development protocols and subproject management and evaluation tools should be used consistently by ACCESS and project staff for ongoing facilitative monitoring and planning.

### *2.1.3 Family Planning Service Delivery*

**How, and to what extent, has ACCESS provided quality family planning to women, particularly young, low-parity women?**

#### Accomplishments

Quantitative Achievements and Results. ACCESS has established effective and, in many cases, innovative strategies for delivering quality family planning services to highly disadvantaged groups in difficult to reach geographic areas and in challenging environments. In 1995, ACCESS implemented 20 subprojects in five countries: India, Nepal, Kenya, Nigeria; a subproject is about to begin in Tanzania.

ACCESS has achieved an array of important results in family planning. A summary of these results, based on analyses of ACCESS service statistics, is presented in Box 1 in the Executive Summary.

Service Delivery and the CEDPA Model. While the data presented above suggest that the project is on track, and that subprojects have achieved substantial results, the information fails to capture the diversity of ACCESS subproject strategies and the ways in which ACCESS incorporates the key elements of the CEDPA conceptual model (empowerment, partnership, with an emphasis on participation and institutional strengthening) into service delivery strategies.

ACCESS has employed three basic approaches to service delivery. These are: (1) the establishment of new family planning NGOs; (2) the strengthening of existing family planning projects; and (3) the addition of family planning to other sector programs or existing infrastructure or networks. For a brief description of the various ACCESS service delivery strategies, see Matrix 1 - ACCESS Service Delivery Strategies.

In each subproject, ACCESS employs a holistic approach to family planning service provision by incorporating the key elements of empowerment, partnership with an emphasis on participation, and institutional strengthening. While these concepts are discussed in greater detail in other sections of this report, they are briefly highlighted here to underscore the ways in which ACCESS attempts to integrate these concepts into the delivery of services.

Empowerment. The CEDPA model views training as a principal catalyst for women's empowerment. It starts with the WIM training for each subproject's senior managers, followed by intensive training at all levels, including for supervisors, field-workers, and CBD agents. The CEDPA training program aims to provide women and men with the skills, knowledge, self-confidence, and expertise needed to manage complex service delivery efforts in challenging environments. The emphasis on participatory management and leadership, rather than solely on technical skills,<sup>1</sup> and the diversity of the training modules, as well as refresher training, helps to ensure that managers and staff are given new knowledge and capacities to implement programs in cultural settings where lack of family planning acceptance is anticipated.

The evaluation team saw evidence of the effects of CEDPA training in the subprojects the team visited. It was reflected first and foremost in the quality of managerial leadership—by the very capable women and men who headed and supervised ACCESS service delivery efforts.

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<sup>1</sup>ACCESS's emphasis on management, rather than solely on technical training, appears to be consistent with lessons that have emerged from other successful family planning programs. For example, in 1982 the Tunisia family planning program decided that the program's managers would be trained in modern management methods, rather than in technical topics only as they had been in the past. Between 1981 and 1988, the program registered the largest increase in contraceptive use in its history and is now considered one of the most successful programs in the international development community. While many factors contributed to these results, a recent evaluation of the Tunisia program indicated that management improvements played an important role in contributing to the increase in prevalence in the 1980s (USAID, 1992).

## Matrix 1

### ACCESS Service Delivery Strategies

<p>Establishment of New NGOs</p>	<p><b>Kenya:</b> Family Life Promotion and Services, FLPS. Founded by two CEDPA alumni, the FLPS serves the informal business sector in Nairobi. A network of 80 outreach workers conduct IEC and make referrals to the FLPS' storefront clinic, located near the central bus depot. Target groups include commercial sex workers and truck drivers. This subproject is being replicated in Kisumu.</p> <p><b>Results:</b> Percentage of project completed: 88 percent Clients recruited as a percentage of objective: 130 percent</p> <p><b>Mali:</b> ACCESS has funded the Mali project through the Ministry of Health (MOH) from 1991 to 1994 through a buy in from USAID/MALI. However, funding was to be withdrawn since USAID was interested in supporting the private sector and indigenous NGOs. ACCESS worked with the Project Director to form a new NGO (ASDAP) to continue services to the three sites in rural Mali. With technical assistance in financial, MIS, program, fundraising and training, the new NGO is now positioned to expand its funding and programs.</p>
<p>Strengthening of Existing Family Planning NGOs</p>	<p><b>Kenya:</b> Family Planning Association of Kenya/Taita. This subproject, using CBD agents and a rural outreach model, has expanded the choice of methods available in hard to reach and isolated communities by offering voluntary surgical contraceptive services, through linkages with AVSC International and the Ministry of Health.</p> <p><b>Results:</b> Percentage of project completed: 82 percent Clients recruited as a percentage of objective: 100 percent</p> <p>Kabiro-Kawangware Health Care Trust. Initiated in 1979, this was one of the first integrated community development programs in Kenya. After over 20 years of support by other organizations, there were few family planning acceptors. In 1994, ACCESS upgraded the clinic, improved service quality, provided WIM training to the project director, provided other project training staff, and expanded family planning through MCH. Male CBD agents were added to reach other men and youths.</p> <p><b>Results:</b> Percentage of project completed: 83 percent Clients recruited as percentage of objective: 355 percent</p> <p><b>India:</b> Prerana Population Resource Center. Recognizing the need for a local NGO in Uttar Pradesh to provide training and technical support to other NGOs in family planning, and support the USAID/India-funded Innovations in Family Planning Project (IFPS), ACCESS established the PPRC in Lucknow, Uttar Pradesh.</p>

Matrix 1

**ACCESS Service Delivery Strategies (Continued)**

<p>Strengthening of Existing Family Planning NGOs</p>	<p><b>Nepal:</b> Nepal Red Cross. Through linkages with the Red Cross, which has a strong infrastructure throughout Nepal, ACCESS is able to serve remote, underserved areas where there are no indigenous NGOs. As a result, ACCESS is one of the largest community-based USAID family planning projects in Nepal. <b>Results:</b> Percent of Project Completed: 58 percent Clients Recruited as a Percent of Objective: 36 percent</p> <p><b>India:</b> Bihar Dairy Cooperatives. The Rural Family Health project, implemented by the Bihar State Cooperative Milk Producers Federation (COMPED), has demonstrated the feasibility of using a dairy cooperative infrastructure to provide family planning and MCH services to rural communities. <b>Results:</b> Percent of Project Completed: 57 percent Clients Recruited as a Percent of Objective: 59.4 percent</p> <p><b>Nigeria:</b> Women's Networks. More than 1,200 CBD agents from ten ACCESS subprojects were trained to provide non-clinical methods to under-served groups through networks, which include urban markets, the informal business sector, women's cooperatives, traders, religious associations, and agricultural workers. (Technical assistance only was provided.)</p> <p><b>India:</b> Gujarat State Crime Prevention Trust. This subproject, directed and led by a CEDPA alumni, added family planning to an existing social services program which provides services to a slum community of Ahmedabad City. <b>Results:</b> Percent of Project Completed: 81 percent Clients Recruited as a Percent of Objective: 82 percent.</p> <p><b>Kenya:</b> Maendeleo Ya Wanawake, (three districts of Kitui, Machakos, and Embu) adds family planning services to a country-wide network of grassroots women's organizations. <b>Results:</b> Percent of Project Completed: 82 percent Clients Recruited as a Percent of Objective: 350 percent.</p> <p><b>Uganda:</b> YWCA, (the largest YWCA in the world with over 1 million members) added family planning clinics in Kampala and Mbale and through CBD workers through YWCA clubs and other outposts. This strategy expanded the Y's capability in programs and strengthened other institutional systems such as financial management and data collection. Broadening the range of services to include family planning and STD/HIV prevention increased the visibility and utilization of YWCA's programs for young adults and youth. <b>Results:</b> Percent of Project Completed: 100 percent Clients Recruited as a Percent of Objective: 104 percent.</p>
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Partnership and Participation. CEDPA's service delivery subprojects are designed and implemented with an emphasis on community participation, support, and ownership. All subprojects are designed after a community needs assessment and in this way aim to reflect the vision and concerns of local communities. CEDPA's emphasis on training in participatory management styles is reflected in the comments of CEDPA alumni. (See Box 3 - Comments of CEDPA Alumni on WIM Training.) CEDPA alumni interviewed by the evaluation team stressed the importance of this aspect of the training. The evaluation team saw the results of CEDPA's emphasis on participatory management during field visits. Supervisor and service provider relationships were relaxed, caring and supportive. They were characterized by a willingness to confront and discuss problems openly and candidly. During group meetings with CBD workers, the evaluation team noticed CBD workers' willingness to speak openly in front of their supervisors and CEDPA managers concerning issues and problems.

Institutional Strengthening. ACCESS provides ongoing and intensive training and technical assistance to strengthen the institutional capacity of the local organizations responsible for implementing ACCESS subprojects. ACCESS has developed a diverse range of institutional strengthening training modules that include the following topics: management, supervision and evaluation, management information systems (service statistics), reproductive health (including AIDS/HIV/STDs), quality of care, and institution building. An overview of the technical assistance and training provided to ACCESS subprojects is provided in Appendices G and H. In addition, training and refresher training is provided at all levels (supervisors, service providers, depot holders).

#### *2.1.4 Promising Service Delivery Models*

ACCESS has designed and implemented several service delivery models that appear promising. Two of these models are currently being replicated in Uttar Pradesh, under the USAID IFPS project.

To provide examples of the ways in which ACCESS attempts to incorporate its model of development into service delivery, two subprojects are discussed below. They represent examples of the addition of family planning to (a) existing rural infrastructure; and (b) an existing urban social services program. Both subprojects used a combined CBD- and depot-holder strategy for delivering services, as described in Box 9.



### **ACCESS Combination CBD and Depot-Holder Strategies**

- India. The Rural Family Health Project (RFHP), implemented by the Bihar State Cooperative Milk Producers Federation (COMPFED), utilizes a combined CBD and depot holder model of service delivery to provide family planning and reproductive health services to 13,000 clients in 240 dairy cooperative societies (DCS). The milk collection sites are referred to as milk depots and the DCS secretaries are trained to provide contraceptives to men during milk procurement hours in the mornings or evenings. Utilizing the depot-holder strategy in the Samastipur district of Bihar has been an effective way of reaching men and getting them involved in the decision to use family planning. This strategy may explain the relative success of the project in obtaining condom acceptors in Bihar and Uttar Pradesh.
- India. The Family Planning Information, Education, Communication, and Services Delivery Project, implemented by the Gujarat State Crime Prevention Trust (GSCPT), uses a combined depot holder and CBD service delivery model to provide family planning services and education to low parity women in eight urban slum communities in Ahmedabad. To date, the depot holders have supplemented the efforts of CBD workers by working from their homes to resupply clients with contraceptives.
- Nepal. In Nepal, many districts are extremely remote from the closest government health posts. To meet the family planning needs of the women in six project districts, the Nepal Red Cross Society (NRCS) has utilized a combined CBD and depot-holder model of service delivery. The depot-holder system has strengthened and extended the existing distribution of services, while providing a low-cost alternative to the paid field-worker system. As women in the area enjoy little mobility, the CBD workers and depot holders often serve as their only contact with health providers. The Family Planning Association of Nepal (FPAN) has adopted a similar strategy in two of its districts—Dhanusha and Dhankuta.

The Addition of Family Planning to Existing Rural Infrastructure–Bihar State Cooperative Milk Producers Federation. This subproject provides family planning services through the extensive, grassroots network of dairy cooperatives. By expanding contraceptive choice and improving access to services in a conservative area of widely dispersed villages, where transportation is minimal, many women live in seclusion, and the need for privacy prevents women from seeking services, the project is demonstrating the feasibility of adding family planning to existing infrastructure, such as cooperatives. Bihar's literacy rate, the lowest among all Indian states (38.5 percent, with female literacy at 23.1 percent), underscores the difficulty of working in this environment. ACCESS's internal evaluations and a draft Population Council study (Rao, Townsend, and Khan, 1995) both indicate that positive outcomes have occurred. A more precise understanding of the nature and degree of these outcomes will require additional data collection and analysis. ACCESS plans to do this after the subproject reaches its full geographic coverage. These data sets reveal the following:

- **Contraceptive Prevalence.** ACCESS research shows that, in some villages, prevalence has increased from 20 to 50 percent. The Population Council analysis indicates that prevalence increased from 23.4 percent in 1992 (spacing methods: 4.2 percent; sterilization 19.2 percent) to 27 percent (spacing methods: 2.1 percent; sterilization 24.9 percent) in 1994 and female sterilization accounts for most of the change in prevalence to date. ACCESS staff indicate that the reason for this difference in prevalence may be due to the villages chosen for study. CEDPA surveyed villages where there had been more activities undertaken by field-workers, while the Population Council survey was of a sample of villages where field-workers had not yet undertaken the full range of outreach activities.
- **Knowledge of Spacing Methods.** The Population Council analysis indicates that knowledge of pills increased from 56 to 87.9 percent, knowledge of condoms increased from 46 to 85 percent and knowledge of intrauterine devices (IUDs) increased from 49 to 62 percent.
- **New Client Method Mix.** According to ACCESS service statistics from the beginning of the project to March 1995, among new clients and referrals, 44.8 percent accepted pills, 46.6 percent accepted condoms, 7.1 percent accepted sterilization and 1.4 percent accepted IUDs. The Population Council study, using project service statistics for a sample of 40 villages, found a similar pattern: 37 percent accepted pills, 57 percent accepted condoms and 5 percent were referred for sterilization and IUDs.
- **Continuation with Family Planning.** ACCESS data indicate that by the 11th quarter, almost 89 percent of clients had been served the previous quarter. ACCESS focus group discussions revealed that clients were satisfied with the quality of services. The village health workers (VHWs) frequent follow-up system may have contributed to continuation. This system encouraged method switching from less effective to more effective contraceptive methods and provided method-specific information.

- **Maternal and Child Health.** The Population Council study indicates that the number of children who had been given all three doses of DPT increased from 18 to 23 percent between 1992 and 1994; BCC vaccine coverage of children increased from 21 to 33 percent. The percentage of women receiving two doses of tetanus toxoid increased from 31.3 to 43.8 percent.
- **Costs.** The Population Council study indicated that a new client could be served for about US\$5 to US\$6. An increase in the CPR by one percentage point could be achieved by spending US\$8,695 initially, including start-up costs.
- **Conclusions.** The Population Council study concluded that this type of CBD model is relatively expensive in the short run. ACCESS staff have pointed out that the cost of this model, like other service delivery projects worldwide, is relatively greater in the start-up phase. Over the long term, however, costs are reduced as the subproject gains more acceptors. The Population Council study also added some important cautionary notes. First, three years may be too short a time to observe measurable, major changes in the use of spacing methods. The subproject substantially increased knowledge of family planning, an important precursor of behavioral change. Second, the project provided maternal and child Health (MCH) services and the multiple and composite effects were not costed. Third, more difficult to assess potential benefits such as empowerment or increasing acceptability of contraceptive use in the community were not measured. And fourth, cost issues are only one of several criteria that should be used in making decisions about replicability.

Key aspects of CEDPA's holistic approach, as seen in the Bihar subproject and which appear to have contributed to program outcomes, are presented in Box 10.

The replica of the Bihar Dairy cooperatives model currently being implemented in Uttar Pradesh State, with CEDPA assistance under the USAID Innovations in Family Planning Project, has now analyzed three years of service statistics. These analyses indicate that the new project trends are positive. SIFPSA has indicated concerns about the cost of the UP subproject, and wishes to undertake additional analyses before further replication in the state. The evaluation team did not have sufficient time to examine cost issues in UP.

The Addition of Family Planning to an Urban Social Services Program—Gujarat State Crime Prevention Trust (GSCPT). The Gujarat State Crime Prevention Trust, a social welfare organization established in 1979, serves the needs of the most vulnerable and underserved groups, women and children in the dense urban slums of Ahmedabad city. In 1987, CEDPA funded a proposal by two CEDPA alumni to add family planning to the list of services provided by the GSCPT. According to an ACCESS internal evaluation, positive outcomes have occurred. Project data show the following:

- **Contraceptive Prevalence.** By 1991 contraceptive prevalence had increased to 61 percent from 12 percent in 1987 and knowledge of family planning methods and the advantages of birth spacing had become almost universal.

**CEDPA's Model for Sustainable Development as Incorporated in the Bihar Subproject**

*Institutional Strengthening:* Since the project began, ACCESS has provided the Bihar subproject with an ongoing and intense program of training and technical assistance at all staff levels. Between 1991 and 1994, the project trained a total of 438 subproject VHWs, supervisors, and depot holders. Additional evidence of the wide-ranging nature of the Bihar institutional strengthening effort is presented in Appendix K. In addition, the cooperatives, as parastatal organizations, are able to take advantage of their status as nongovernmental organizations, while retaining linkages with policy-makers and senior government staff. The director and the vice-chairman of the project's monitoring committee are both from the Indian Administrative Services system. Given this relationship with the public sector, ACCESS encouraged reliance on government health facilities for referrals, immunization and contraceptive commodities, in addition to both technical and leadership training. The male Cooperative Management Boards at all levels (community to state level) have supported the project and it is anticipated that they will endorse strategies for financial sustainability when ACCESS funding terminates in 1997. A financial sustainability plan is currently being implemented.

*Participation:* Village health workers (VHWs) were selected by community leaders and preference was given to those residing in the community they served. The subproject recruited workers from every level of the caste hierarchy.

*Empowerment:* The project increased women's knowledge about spacing methods in an area where sterilization is the predominant method, thus giving women more choices and greater control over their reproductive health. In addition, qualitative research sponsored by USAID and conducted by the Population Council indicated that some subproject clients accepted family planning despite strong opposition from their husbands and mothers-in-law (Parveen, Khan and Patel, 1994). Door-to-door, community-based distribution provided the privacy crucial for women in seclusion. At the beginning of the project, the women did not accept contraceptives when they were made available at the depot. It was only later, after contraceptives were provided in the privacy of their own homes, that women felt comfortable accepting family planning. The project also ensured that health supervisors and VHWs received both technical and leadership training that stressed the building of self-esteem and confidence. Finally, the subproject provided a small stipend to the VHW which enhanced her value in the family.

- **Coverage.** Between 1991 and 1995, the area of coverage tripled. The subproject currently covers a population of approximately 700,000. Twenty CBD workers are each responsible for an area of 5,000 families.
- **Continuation with Family Planning.** Over a three year period, only 684 clients (10.8 percent) dropped out of the program. The subproject emphasized the continued use of contraceptives and paid careful attention to resupply, identifying complications, and counseling dissatisfied clients. They assisted in method switching to ensure satisfaction.

The ways in which ACCESS incorporated the CEDPA model into service delivery which appear to have contributed to these results are presented in Box 11.

Service Delivery and Advocacy. ACCESS's knowledge of service delivery issues at the local level, coupled with its expanding in-country alumni base of trained and articulate leaders, gives the project a unique comparative advantage in the areas of advocacy for family planning and reproductive health. In considering which types of advocacy groups to support, USAID should consider recent research findings on the types of advocacy activities that are critical for policy reform (Crouch et al., 1994; Porter 1995). These studies contend that policy reform, frequently a long and slow process, is more likely to occur when local groups understand the issues, feel they have a stake in and ownership of the process, and become mobilized to undertake advocacy on their own. According to these findings, donor funding of advocacy groups that have minimal roots in local communities is less likely to lead to genuine and meaningful reform. Policy reform at the national level is made possible only by support from the local level. This research would argue for USAID's supporting community-level service delivery activities that are closely linked to advocacy.

Quality of Care. As documented in part by the relatively high method continuation rates in the case studies discussed above, ACCESS training provides staff and alumni with the necessary knowledge and skills to design and provide high-quality services. To assess the quality of care in the other subprojects, the evaluation team participated in ten group meetings with both clients and CBD workers (in the Kabiro, Kisumu, Family Planning Association of Kenya--Taita, and Family Life and Promotion Services [FLPS] subprojects in Kenya; in the Gujarat subproject, and Dairy Cooperatives replica subproject of the Innovations in Family Planning Project in India).

All group meetings conducted by the evaluation team (five with clients and five with CBD workers) indicated that clients highly valued the CBD workers, trusted the information they provided, and viewed the services as high quality. In some cases, the CBD workers' role went beyond family planning service delivery and became more of a general agent for change in the community. Some administrators discussed how CBD workers assisted women who had been physically abused; others indicated they counseled very young women not to marry at a young age. During group meetings in Gujarat, clients stated that the CBD agents come door-to-door and spend at least 15-20 minutes with each woman explaining the methods in detail; personally take them to the government hospital for IUD insertion or sterilization; visit clients regularly, and ask if

### **CEDPA's Model for Sustainable Development as Incorporated in the Gujarat Subproject**

*Empowerment.* This subproject grew out of a CEDPA-sponsored workshop. The women managers who prepared the proposal to add family planning to their social services portfolio had little experience with family planning. To succeed, they would have to be empowered with a new range of skills to implement a family planning program in a challenging setting—supervision of staff having no technical skills, mobilization of an uninterested community, health education of illiterate clients, and the introduction of temporary and untried contraceptive methods.

*Participation by and Partnership with Clients and Community.* The subproject emphasizes a client-oriented approach. The Trust staff believe that its very personal, woman-to-woman approach has been critical in reaching isolated and illiterate women in the slums, and in a culture in which discussion of personal topics is difficult. An ACCESS internal evaluation reports that the subproject's participatory management style has meant that channels of communication between supervisors and field-workers are open and nonthreatening. Field-workers meet weekly with supervisors to review service statistics. This contributes to multi-level participation in decision making and a mutually supportive team. Moreover, the quality of the relationship between the providers and the clients is very good, as evidenced by the group meetings with Gujarat clients conducted as part of this evaluation and discussed below. The subproject's emphasis on temporary methods requires close and ongoing support of clients; and the providers support the clients in many ways that go beyond the provision of family planning services.

Finally, field-workers were actively involved in the referral process, often accompanying clients to a government clinic or hospital for IUD insertion or sterilization. The clients indicated that they appreciated this support, since government facilities were impersonal and failed to respond to their needs for privacy and quality care. The evaluation team's site visit indicated that the subproject was highly regarded by the government and the community. It was able to access the community through existing social service outlets—e.g., child care and youth centers—and use these as vehicles for education and distribution.

*Institutional Strengthening.* ACCESS provided a range of training and technical assistance activities. It demonstrated that, with careful attention to institutional strengthening, a nonfamily planning organization can successfully provide family planning services. Between 1992 and 1994, ACCESS trained a total of 178 field-workers and depot holders for service delivery through the GSCPT.

there are problems; maintain a register, and take clients to replace the IUD after two and one-half or three years; and talk to clients about the importance of immunizing the children. The group meetings conducted by the evaluation team did not reveal negative views of the CBD workers. As discussed in Section 2.1.6 on sustainability, ACCESS subprojects are beginning to charge fees for services. Some clients are willing to pay and this indicates confidence in the quality of service. Comments from clients and managers related to quality of care and the role of CBD workers as change agents are presented in Box 12.

The existing ACCESS MIS, based on subprojects' service statistics, provides information on some aspects of quality of care: method mix, parity, referrals, numbers of resupply/revisits, method switching, and reasons for drop out by method. These data, analyzed quarterly both in the field and in Washington, provide quantitative information on select quality elements, such as method availability, appropriateness of methods, technical competence of the providers and continuity of care. In this way, ACCESS has attempted to use routine data collection through the MIS to monitor quality of care.

In 1994, recognizing that quality of care indicators and tools were most useful when tailored to the subproject and cultural context, ACCESS developed a core set of quality of care indicators that could also be monitored and reported quarterly as part of the existing system used to report service statistics. Subsequently, in 1994-1995, CEDPA conducted Quality of Care workshops in India and Kenya to introduce the core set of QOC indicators and to assist subproject staff in the development of subproject-specific indicators for QOC, STD/AIDS, empowerment, and gender. Workshop participants then designed various tools to collect the information on their indicators. These included CBD supervisory checklists, annual client satisfaction surveys, clinic checklists (for example, for adherence to infection control, medical standards, and client flow) and organizational assessments of systems to support quality services.

In addition to providing Quality of Care workshops for subproject staff, other activities undertaken by ACCESS to promote quality service delivery includes the following:

- **Choice of Methods.** In the Kenya Taita-Taveta subproject, an isolated area where permanent methods were previously unavailable, ACCESS developed a system of effective referral to AVSC International (AVSC) trained hospitals; CBD workers are thus demonstrating the feasibility of formal referral linkages.<sup>2</sup> In this same subproject, CBD workers also recruited 300 NORPLANT® acceptors shortly after it became available to the subproject. ACCESS also incorporates the depot-holder approach in many subprojects, in which women and men stock and sell pills and condoms in their homes upon demand.

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<sup>2</sup> An effective referral is defined as a male or female client who was referred by subproject staff to a non-subproject facility, and who was confirmed to have received a family planning method.

Box 12

**The ACCESS CBD Worker as Quality Service Provider and Change Agent:  
Comments from Interviews and Group Meetings with Clients and CBD Workers**

*"The CBD agents tell the women that they do not have to be beaten [when they try to insist on condom use by their partners]... they have rights." Program administrator, Kabiro-Kawangware subproject*

*"We trust the CBD agent, and she doesn't have a big mouth." Kabiro-Kawangware client, Kenya*

*"The CBD worker should be paid more, she does too much voluntary work. We would agree to pay her more from our own pockets." Kabiro-Kawangware client, Kenya*

*"[If services provided by the CBD worker were to end] It would be very bad. We would just go back to the old days." Taita-Taveta client, Kenya*

*"[The CBD workers] take a lot of time to discuss permanent methods." Taita-Taveta client, Kenya*

*"Most clients of NORPLANT® are those who have trust in the CBD worker." Taita-Taveta client, Kenya*

*"We tell the mothers not to let their daughters marry at such a young age— before age 18." CBD worker, Dairy Cooperatives, Uttar Pradesh, India*



- **Client-Provider Interaction.** ACCESS trains field-workers in client-centered education and counseling, emphasizing the individual's right to choose the appropriate approach and method to attain their reproductive health goals.
- **Technical Competence of Providers.** ACCESS provides training to nurses and other clinic staff in infection control procedures (the evaluation team was asked to remove their shoes before entering an examining room in a Nairobi slum as an infection control measure) and field medical officers, trained by a Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) or others, provide medical guidance. In Kenya, the Kenya Medical Women's Association, has undertaken a series of medical/quality reviews of ACCESS subprojects and provides pediatric and other services to the subprojects. The evaluation team did not have time to assess the quality of care at referral clinics.
- **Appropriate Method Mix.** In isolated rural areas, ACCESS has worked to develop effective referral systems to increase access to permanent or longer acting methods. In areas where only permanent methods are usually available, for example in India, ACCESS has introduced spacing methods. The local medical advisor in India was recently trained at Georgetown University. In FLPS, a subproject in Kenya whose client group includes commercial sex workers and truck drivers, condom distribution is an important element of the program.

### Concerns

- ACCESS employs the indicators of "new clients recruited" and "new clients recruited as a percent of objective" as measures for monitoring progress. Since new clients may quickly drop out of the program, these are imperfect indicators of achievement. Equal emphasis needs to be placed on method continuation. Interviews suggested that despite the Quality of Care workshops conducted in the field, client satisfaction surveys, although planned, have not yet been conducted and, with the exception of the Bihar and Gujarat subprojects, ACCESS has not examined client continuation rates in a systematic way. ACCESS staff acknowledge that dropout data are very new, limited to a few subprojects, and are not yet reliable.
- Interviews with subproject managers suggest that quality of care tools are not always used as consistently or effectively as they might be. While this is to be expected after the introduction of new tools and approaches in a field setting (for example, after the Quality of Care workshops), ACCESS will need to review its practices in the field to ensure that these are actually used for management and implementation.
- While CEDPA has emphasized management training as a key element for improving service delivery, ACCESS appears to give less attention to internal processes needing improvement, the measurement of these processes, and the development of process improvement activities. "What gets measured gets done" is an axiom of leaders in management excellence. ACCESS will need to identify those processes needing improvement in their subprojects such as waiting time in clinics, contacts by

CBD workers, availability of contraceptive supplies, among other process indicators, and establish appropriate measurement procedures.

- ACCESS's potential for implementing effective service delivery programs and testing new strategies has been constrained by USAID and host government decisions due to the following reasons:
  1. USAID/Washington's decision to reduce the levels of the USAID/Kenya program;
  2. The Government of India's decisions requiring CEDPA/ACCESS to remain in New Delhi while the IFPS project is implemented in another state, Uttar Pradesh, as well as other implementation constraints; and
  3. Shifting USAID priorities and strategies requiring ACCESS to transfer subprojects to other donors; for example, in Mali, Egypt, Turkey, and Uganda.
- While ACCESS has begun to examine the full costs of service delivery in two subprojects, FPLS and the Family Planning Association of Kenya (FPAK), it has yet to examine these issues across the board. To improve efficiency and cost-effectiveness, as well as make progress in the area of financial sustainability, ACCESS needs to examine the actual costs of service delivery, as well as undertake studies of clients' willingness to pay. Given ACCESS's stated desire to make progress in the area of financial sustainability, it will need to monitor cost trends in both the subprojects and in CEDPA as a whole, and link this information with planning for financial sustainability.

## **Recommendations**

12. As a high priority, to reduce the risk of early and unplanned pregnancy and parenthood and exposure to STDs and HIV, over the next 5-10 years, ACCESS should focus on 13-18-year-old boys and girls by seeking opportunities to integrate reproductive health and family planning education and gender sensitivity training for this group into ongoing programs.
13. ACCESS should continue to work to improve quality of care and use method continuation rates as an important indicator of service quality. Specifically, ACCESS should establish procedures to examine method continuation rates on a regular basis, with regular and frequent assessments of the most effective ways to encourage method continuation. As planned, they should also conduct client satisfaction surveys as part of their internal monitoring procedures and work to improve the quality of dropout data. ACCESS should continue to identify other service processes (for example, clinic waiting time) that reflect quality service delivery and establish appropriate measurement procedures.
14. As a high priority, ACCESS should accelerate its efforts to reach men with family planning education and other services.

15. USAID should examine the replica of the ACCESS Bihar Dairy Cooperatives subproject currently being implemented in Uttar Pradesh with a view toward expansion and replication in the state. USAID and CEDPA should also examine the lessons from Bihar Dairy Cooperative and Gujarat Trust subprojects and apply them as appropriate in Uttar Pradesh.

#### *2.1.5 Family Planning Integration with other Health Services*

### **How successfully has ACCESS integrated reproductive health into its existing family planning programs?**

#### Accomplishments

ACCESS has made progress in moving beyond strictly family planning services into a more comprehensive reproductive health care program. Not all subprojects are equally integrated but there is great demand at the community level for a broader range of services and subprojects to respond as their resources permit. The following shows the services available in each subproject.

Kenya. In Kenya, the FLPS subproject targets commercial sex workers and the public at a busy bus terminal in Nairobi. It was the first ACCESS subproject to integrate STDs/AIDS information, diagnosis, and treatment into ongoing family planning services. Based on this experience, ACCESS developed a manual on STDs/HIV/AIDS aimed at service providers and CBD workers to improve counseling skills. The manual is used by other CAs and has been commended for its practical, field-based approach. Working with the Ministry of Health in Kenya, a syndromic approach to STD diagnosis was developed and service providers trained in the diagnosis of STDs without laboratory testing.

Also in Kenya, the Kabiro Kawangware project near Nairobi and the Maendeleo Ya Wanawake project in Kitui provide MCH services and perinatal care through referrals to the Ministry of Health clinics or the national hospital, Jomo Kenyatta National Hospital, and the Kabiro project is staffed with volunteer physicians from the Kenya Medical Women's Association. After attendance at a CEDPA workshop, the manager of the project attended a WIM training in Washington, returned to her project and made dramatic changes in the way the project was run. Infection control was greatly improved, as were staff skills in counseling.

CEDPA is a member of the CA service delivery working group in Kenya. The coordinating CA, Pathfinder International, says that CEDPA is unique in its targeting of CBDs in Kenya and its training manual for CBDs is excellent. They report that CEDPA is particularly strong in looking at reproductive health from a culturally sensitive perspective. CEDPA (along with Pathfinder) was reported to be much ahead of other CAs in identifying client needs and providing "one stop shopping" for health and family planning services.

Mali. In Mali, the subproject has a range of STD prevention and MCH services with strong linkages to the MOH facilities for referrals, immunizations, perinatal care, and other reproductive and child health services. The Mali project pioneered in the use of IEC materials with integrated health messages and the use of male CBD workers. The combined strategy led to a 50 percent increase in condom use over a two-year period.

Nepal. In Nepal, both subprojects have addressed the increase in HIV prevalence through special STD/HIV training for CBD workers and innovative, low-cost IEC materials. A special "Condom Day" promotion will be held in connection with major festivals and will use male field-workers to educate other men on child spacing and STD transmission.

Nigeria. In Nigeria, CBD training has included reproductive health components and emphasizes maternal health, and STD prevention along with contraceptive counseling. They have developed special IEC materials for non-literate women, and have developed gender specific messages for men and women. Recent requests from the communities have added child survival programs (ORT, immunization, treatment of common ailments) and safe motherhood services for mother and child.

Uganda. In Uganda, the YWCA subproject is the first ACCESS effort to promote reproductive health services for youth through a successful youth leaders and peer counseling program. The peer educators were very effective in reaching other youth through their own social networks and places where youth frequent.

India. In India, the GSCPT in Gujarat and the RFPH in Bihar have responded to requests from the local communities to expand their service delivery with STD and reproductive health services. The USAID-funded replication of the RFPH project in Uttar Pradesh has followed the same path.

Most STD programs in India target men. While ACCESS staff in India have developed an excellent STD/AIDS strategy that targets women, and the Gujarat project is planning a second training for its CBD workers, there is little public interest in AIDS prevention, because of an apparently low prevalence rate. The lesson from Africa is that AIDS can only be controlled when the prevalence rates are low. The addition of a reproductive health consultant will strengthen this effort.

### Concerns

- As health services in the communities where the subprojects operate are limited, CBDs and the subprojects are under increasing pressure to provide medical/clinical services such as first-aid, child delivery, care of common ailments, and secondary care. These demands may overwhelm the referral system and go beyond the training of CBD workers. Moving from primary and preventive services to curative care is a major policy move that requires a different training and referral system than the standard family planning/CBD service. Family planning would be at risk if curative services were to be added to CBD workers' responsibilities. ACCESS has no policy on the establishment of clinics and the services that should be funded.

## Recommendations

16. ACCESS should continue to integrate STD/HIV initiatives into all of its projects with accelerated efforts in high risk countries. The STD/HIV initiative in India should be accelerated. Reproductive health, however, was not part of the original ACCESS design. ACCESS is developing indicators for STD/HIV in each subproject. In the next phase of the project, the ACCESS mandate, mission, and strategy should be broadened to acknowledge reproductive health objectives. ACCESS should continue to develop and monitor corresponding indicators that reflect the types and quality of services in each subproject.
17. Although subprojects are under pressure to move into secondary and curative care, CEDPA projects should stay focused on primary care (prevention of illness and the promotion of healthy behavior through education). Where referral and backup is needed, CEDPA should continue to find partner organizations and institutions with clinical expertise who can undertake those services. CEDPA should not move into general health care. ACCESS needs a clear policy statement on the level of clinical services it is prepared to support, taking into consideration that the FLPS and Kabiro-Kawangware subprojects are using the diagnosis of STDs and the sale of drugs as an income generating mechanism.

### *2.1.6 Sustainability*

#### **To what extent are local organizations more sustainable, especially institutionally sustainable, as a result of receiving support from CEDPA/ACCESS?**

##### Accomplishments

ACCESS has taken important steps toward developing an integrated sustainability strategy. The strategy is based on a conceptual model of sustainability that moves family planning organizations along a continuum to institutional, financial, and political sustainability. ACCESS defines sustainability as follows: "The ability of an institution to continue the delivery of quality services, mobilizing its managerial, financial, and human resources to foster community participation and insure diversified funding support so that it can function independently."

The key strategies of the ACCESS sustainability model are:

- Identifying organizations, often led by CEDPA alumni, that are committed to the provision of quality family planning services
- Establishing long-term, reciprocal partnerships between individuals and organizations
- Collaborating with partners in developing and implementing plans for sustainability
- Building learning organizations through facilitative monitoring and collaborative planning with ACCESS

- Participation of stakeholders, including community leaders, community members, staff, and clients to ensure appropriateness and ownership of the program

The model reflects ACCESS's experience in facilitating the growth of partner organizations toward sustainability. It outlines stages of institutional development in the areas of planning and management systems, human resource development, service delivery systems, community support and financial resources. (See Box 13 - Capacity Building for Sustainable Institutions.)

CEDPA projects have proven to be replicable and sustainable. The Family Life Service Program (FPLS-Kenya) in Nairobi has been replicated in Kisumu and in India, the Bihar State Cooperative Milk Producers Federation, Ltd. "Rural Family Health Project" (RFHP-Bihar) is being replicated through the Uttar Pradesh (UP) Dairy cooperatives. Also in India, the GSCPT Family Planning IEC and Service Delivery Project is being replicated in UP.

ACCESS has consistently implemented CEDPA's stated philosophy of working in equal, long-term partnership with NGOs to assure local ownership of projects. A Pathfinder staff person in Kenya said: *"They [ACCESS] tailor programs to needs of the community and work within the community. We all try to do this but they do it better and with challenging communities. It takes guts; they stick with it and make it work."*

ACCESS has honored its commitment to partners even when subproject funding was stopped due to changing USAID policy and priorities. In all cases they leveraged alternative funding and supported partners to continue activities. Eleven of 12 projects have continued. Only the Turkish Municipal project has been closed due to changes in political support. (See Box 14 - Closed Subprojects/Countries.)

Financial Sustainability. ACCESS works with partners to encourage financial sustainability through the development of financial management systems, diversification of funding (cost recovery, social marketing, fee for service, multiple donors, community contribution) and developing long range strategies for sustainability. Sustainability assessment is a step in the project development process and is included in implementation plans when the partner is ready and willing to try appropriate income generation approaches. While ACCESS is working with its partners to develop financial sustainability, only two of the current subprojects have embarked on an assessment of the true cost of services. This area of sustainability will require ACCESS's greatest attention.

### Capacity Building for Sustainable Institutions

Mali - When USAID alerted ACCESS that support for the successful eight-year-old Ministry of Health Katibougou Project would end due to a change in funding focus, ACCESS worked with the project director to develop an "exit" strategy. With full government and community support, an independent NGO, *Association de Soutien au Developpement des Activites de Population (ASDAP)*, was established to continue activities in the three project sites. ACCESS provided technical assistance to strengthen financial management systems, planning, and program management skills, supported private voluntary organization (PVO) grant development and leveraged other donor support. As a result, ASDAP has emerged as a viable model for expanding CBD programs in Francophone Africa. With its strengthened program capacity and NGO status, it leveraged \$591,000 from four donors to expand its integrated activities over the next five years. (See Appendix J - Mali Case Study on Sustainability.)

Nigeria - ACCESS subprojects have demonstrated the importance of community participation to sustain project activities. Despite political disruption and sporadic funding because of de-certification, projects were sustained and, in some cases, exceeded targets for training, IEC, new acceptors and referrals. This accomplishment was due to the exceptional commitment of staff and the extensive CEDPA alumni network who transported commodities in their own vehicles, co-signed bank loans, and provided technical backup during the seven months when the subprojects had no funds from ACCESS.

India - The Gujarat State Crime Prevention Trust (GSCPT) provided technical assistance through on-site visits and training to the Bihar Dairy Cooperative and Sharmik Bharati in Uttar Pradesh, two ACCESS supported projects which are in early stages of institutional development. In turn, the Bihar Dairy Cooperative provided technical assistance to the Pradeshik Dairy Cooperative in Uttar Pradesh.

CEDPA, acting as the lead CA in the Innovations in Family Planning Services (IFPS) Project, has guided the development of start-up systems for SIFPSA. USAID is pleased with their sensitivity and progress in this complex project and challenging development environment.

Kenya - ACCESS is credited by CA partners as initiating the idea of the "sustainability of the CBD worker" while other CAs were only thinking of the sustainability of the clinics.

Box 14

**Closed Subprojects/Countries**

<b>Name</b>	<b># of Mos.</b>	<b>Purpose</b>	<b>Why Closed</b>	<b>ACCESS Assistance</b>	<b>Current Status</b>
Mali Ministry of Health	38	FP outreach and clinic services	Graduated with planned phase out of Mali buy-in funds	TA in proposal writing, fundraising, training	New NGO developed and implemented as of U.N.
Uganda			USAID/Kampala consolidation of Population/AIDS project		
Young Women's Christian Association	34	Integrate FP/HIV/STD clinic and outreach	To be transferred to Pathfinder	Obtained UNFPA bridge funds for 3 months	Pathfinder funds still not in place. CEDPA raising private funds now.
AIDS Information Center (AIC)	15	Integrate FP with AIDS testing	high risk project	TA to develop continuation plan	AIC continued activities
Egypt			New USAID Pop project did not include NGOs.		CEDPA started new USAID/Cairo grant for girls and young women as a result of ACCESS buy-in
Bishoprhc of Public Ecumenical and Social Services (BPESS)	30	Integrate FP with income generating/ literacy in Upper Egypt	"	Raised UNFPA funds	Continues under UNFPA
Coptic Evangelical Association of Social Services (CEOSS)	19	Community-based development and family planning	"	Raised UNFPA funds and CEDPA private funds	Continues under UNFPA. CEDPA provides new grant to CEOSS for girls and young women



### Closed Subprojects/Countries (Continued)

<b>Name</b>	<b># of Mos.</b>	<b>Purpose</b>	<b>Why Closed</b>	<b>ACCESS Assistance</b>	<b>Current Status</b>
Institute for Training and Research in Family Planning (ITRFP)	30	Training of governors' wives in advocacy for family planning	"	Gov. support continues for Governors' Council of Women	ITRFP now receives funding under CEDPA's new grant for girls and young women. Also has developed as regional training center
Pakistan			Pressler Amendment. No U.S. funds in Pakistan.		
Behbud Association	18	Mobile FP services	"	UNFPA bridge funds	Continues under UNFPA
All Pakistan Women's Association (APWA)	18	Family welfare clinics	"	UNFPA bridge funds and CEDPA private support	Continues under UNFPA and CEDPA private support
Pakistan Voluntary Health and Nutrition Association (PVHNA)	18	Training and support to family welfare NGOs	"	private grants	Continues under CEDPA private support
Turkey			USAID consolidation		
Municipality of Ankara	36	Women leaders and FP clinics/MCH	Political changes in Ankara	Established linkages with other CAs in Turkey	Program closed due to lack of political support
Peru		FP in rural Cusco	Changes in USAID project	Private funds which CEDPA raises annually	Remains open due to private funds from CEDPA

Out of the eight current subprojects, six have multiple options for fund diversification. Two have revolving drug funds, four charge a fee for service or registration fee, and two participate in the social marketing of condoms. The Mali ASDAP project, which has now graduated, has had income generation activities for several years and is charging for training provided to other NGOs. All projects which generate funds have developed systems to properly account for funds and supplies. (See Box 15 - Financial Sustainability Initiatives.) *"ACCESS staff have been very innovative. They have helped us all start to think about cost sharing through the institution of fees for service,"* a Pathfinder staff in Kenya commented.

Political Sustainability through Community Support. The ACCESS model includes political sustainability through community support as the third element of sustainability. ACCESS has enabled partners to work toward achieving a positive political climate by providing training for leaders and communities in community mobilization and facilitating the collaboration with women leaders who are national advocates for family planning in their countries. Alumni have carried forward women's empowerment and reproductive health advocacy without CEDPA/ACCESS direct support. While alumni actions cannot be directly attributed to their CEDPA association, it is worth noting that their actions are gaining broader community support.

Kenya. Two women parliamentarians recently attended WIM training and have become active in the Kenya CEDPA alumni network.

Egypt. Governors' wives and female village council members received training from the Institute for Training and Research in Family Planning (ITRFP) and are now reported to be actively participating in decision making in support of women's concerns.

Nigeria. Chiefs and male leaders were included in the initial step of developing the family planning programs in their communities. The continuation of the programs despite funding setbacks is attributed in part to the leaders' on-going support.

India. GSCPT provided a five-day training workshop for government and political leaders from Gujarat and Uttar Pradesh states as a key element in sustaining support for the GSCPT project and gaining wider support for the SIFPSA projects in UP. The workshop focused on GSCPT's innovative approaches (women-to-women) to family planning service delivery in the urban slums of Ahmedabad and on the role that NGOs can play in service delivery.

The director of the GSCPT, a CEDPA alumni who was sponsored by CEDPA to attend both the population conference in Cairo and the women's conference in Beijing, initiated a nationwide meeting to develop an action plan for newly elected women Panchayat members. The action plan focuses on reproductive and community health and women's empowerment. Plans are under way to seek funding to provide leadership education to the women Panchayat members.

### Financial Sustainability Initiatives

- Kenya - ACCESS supported a study by GTZ (Association for Technical Cooperation), a German development agency, to determine "Acceptability of User Fees in Community-Based Distribution of Family Planning in Kenya." The study suggests that charging fee for service can be applied without much hardship to existing users or discontinuation of use. Focus group members in the FLPS project area indicated their willingness to pay a higher fee because of the hard work of the CBDs. However, rural focus group members indicated that some women would not be able to pay fees for registration.
- ACCESS linked the USAID Health Financing and Sustainability (HFS) Project with the ACCESS FLPS and Kabiro Health Services subprojects to develop their capacity to cost, set-up, and run a revolving drug fund. HFS continues to work with FLPS on a long-range financial sustainability strategy by looking at true operating costs, efficiency and cost effectiveness.
- FLPS and Kabiro have both saved generated funds from fee for service. At FLPS, some of these funds have been used for equipment upgrades so that clients can see the benefit from their fees. They are now seeking ways, with HFS assistance, to invest the remainder of the fund, a sum of US\$20,000.
- India -The Bihar Dairy Cooperative has made three attempts to establish fee for service. The two earlier initiatives were stopped because of resistance from the beneficiaries and government health workers. The current plan for financial sustainability by the end of 1997 includes charging a fee for the convenience of home delivery of the service and continued support from the Dairy Management Committees through their funds and fees. The program director believes that the Management Committees will support the service because members value the service and have become more loyal cooperative members. He correlates the services with sustained milk collection levels during usually low periods, a financial benefit for the cooperative. It is also planned that staff and administration costs can be reduced in the established program. (See Appendix K - Sustainability Model for the Rural Family Health Project - COMPFED, Bihar.)

Mali. ASDAP sponsored a panel of adolescents who shared their experiences of risky sexual behavior to demonstrate the need for adolescents to have access to reproductive health services. The assembled group of medical professionals were moved to reconsider their position on the issue.

### Concerns

- ACCESS partners who have grown out of a social service base frequently do not have the in-house experience and entrepreneurial attitudes to find options to generate income and embrace cost-effective management.
- While USAID has articulated its strategies for sustainable development through long-term partnerships, its strategy changes and budgetary decisions have sometimes made it difficult for ACCESS to maintain sustained partnerships with the organizations it supports.
- A hindrance to charging for family planning commodities or services is the perception by subproject staff that poor people cannot and will not pay fees. They believe that since government services are provided free of charge, NGO services would not be competitive with the public sector if fees were charged. In Kenya and India, the government prohibits the sale of government provided commodities. Yet studies have shown, and focus groups have confirmed, that even the poor will pay for quality, convenient services.
- Project design of the IFPS project in India is such that sustainability is not yet planned. There is apparently no presumption that SIFPSA would be sustained beyond the 10-year project cycle. Neither is there a plan for disengagement of the CAs.

### **Recommendations**

18. CEDPA should develop its capacity to determine the full cost of service delivery, as well as monitor cost trends in CEDPA and its subprojects. In the same vein, ACCESS should expand opportunities to link partners with local organizations or projects which can assist them in developing their entrepreneurial thinking in the context of their mission. Partners need to develop skills in accurate and actual costing of services, plans for reducing current costs and business plans for income generation activities. ACCESS should develop linkages with successful small-scale enterprise projects, including women's credit schemes, to learn lessons about small-scale enterprise cost recovery.
19. As a high priority, ACCESS should review the Quality Assurance Project's integrated approach to sustainability, which also involves methodologies for addressing quality and cost-effectiveness, and consider ways to collaborate with them and use their problem-solving approaches to make progress in these three areas.

20. CEDPA should continue to develop collaboratively with its partners' agreed upon plans for financial sustainability, as part of a strategic emphasis on entrepreneurial thinking and activities. Plans for and education about financial sustainability should be included in the design stage of all subprojects. ACCESS is urged to support studies on willingness to pay in the countries in which it works or use secondary data on the topic if the data are relevant and of high quality. Fees should be instituted as early in the life of a project as possible.
21. CEDPA should continue to diversify its funding base to ensure sustainability of its partnership activities given the uncertainty of USAID's funding and outcomes of mission planning exercises
22. Now that a sustainability conceptual framework has been drafted, the ACCESS team has the opportunity to refine it at the October Planning Meeting. The stages and steps of the conceptual framework need to be linked to proven technical assistance, training, and management systems. All staff and consultants need to use the framework and tools in supporting their organizations toward sustainability. ACCESS should continue to examine and test approaches to enhance the sustainability of the CBD worker, and consider including this idea in the conceptual framework.
23. The long-term sustainability strategy of SIFPSA and the organizations it is developing, as well as the constraints that inhibit CA inputs to SIFPSA, need to be clarified as part of the Management Review of the IFPS Project.

#### *2.1.7 Collaboration with Other Cooperating Agencies*

**How effectively and to what extent has ACCESS collaborated with other Cooperating Agencies (CA), such as the Women's Studies Project and ICWR? What have been the most and least fruitful collaborations and why?**

##### Accomplishments

The evaluation team interviewed six USAID missions (Kenya, India, Mali, Egypt, Nepal, and Tanzania), three CAs in Kenya, six CAs and two professional associates in India, and two CAs in the United States with regard to the effectiveness of ACCESS collaboration with other CAs. The ACCESS project received consistently high marks from USAID Mission staff and from collaborating agencies for its effectiveness and leadership in its collaborating with other CAs.

Two models of CA collaboration were observed. The first is the common model of independently housed CAs collaborating on a variety of projects.

The second is the India model where the CAs who are invited to work on the state-focused IFPS project share an office managed by one CA, ACCESS. ACCESS is responsible for the management and coordination of the IFPS Liaison Office. Activities

include the facilitation of communication among all the IFPS project CAs through weekly meetings and the circulation of trip reports; provision of administrative support, travel, and financial services; and provision and maintenance of office space for the CAs. ACCESS is also responsible for providing technical assistance to support the SIFPSA as a parastatal organization. This includes the hiring of staff, establishing the SIFPSA office, developing all management procedures, and creating a management information system. USAID maintains the role of coordinating CA activities.

The six CAs who were interviewed found the support provided by the ACCESS six-member Liaison Office team to be of high quality and responsive to their needs. The CAs are the Johns Hopkins University (JHU)/Population Communication Services (PCS), JHPIEGO, Promoting Financial Investments and Transfers (PROFIT), AVSC, Resources for the Awareness of Population Impacts on Development Project (RAPID), and the EVALUATION Project. Given the challenging environment in India, where it is difficult to set up a bank account and identify and maintain an office, this logistical arrangement allows the CA representatives to focus on their technical tasks. Most CAs felt that the weekly meetings provided an adequate forum for exchanging information and problem solving.

Examples of fruitful collaboration cited include:

- ACCESS/Headquarters - ACCESS has initiated conversations with the International Center for Research on Women for assistance in the development of empowerment indicators for all ACCESS projects. The two organizations have a long and cordial history, having offices in the same building, but have not worked together prior to this project.
- The Women's Studies Project successfully collaborated with CEDPA/ACCESS in preparation for presentations at the Cairo and Beijing conferences. They found CEDPA able to draw on the skills of women leaders around the world who could enhance the conference discussions.
- Nepal - In collaboration with Private Agencies Cooperating Together (PACT), basic literacy training programs have been linked through the "extremely instrumental" efforts of the ACCESS resident advisor, to women's groups and CBDs in the ACCESS Family Planning Association of Nepal (FPAN) and Nepal Red Cross Society (NRCS) subprojects. There are plans for the groups to continue with an intermediate literacy course, Health Education Adult Literacy (HEAL) facilitated by World Education.
- ACCESS has taken the lead in initiating Condom Day with the subprojects and JHU/PCS and other AIDS organizations. Condom Day will educate men, who are home from India for the holiday season, and their partners through the use of entertaining IEC materials on STD/HIV and the use of condoms.
- Kenya - Pathfinder and CEDPA both support projects with MaendeleoYa Wanawake Organization (MYWO), a Kenyan women's association. The CAs have jointly

assisted MYWO in developing its MIS, accounting, and strategic planning systems, and met monthly to coordinate activities and conduct joint audits. As part of USAID/Kenya CA consolidation plan, Pathfinder will take over the ACCESS districts. Transfer activities have been scheduled to assure continuation of quality service.

- The Health Care Financing Project has assisted the FLPS subproject in its record keeping, accounting, revolving drug fund costing, laboratory charges and fee-setting, and the development of sustainability plans. FLPS has successfully implemented fees for services.
- Two of four Japanese Embassy Small Scale Grants were given to ACCESS subprojects as a result of efforts by USAID/Kenya and the ACCESS regional advisor.
- ACCESS collaborated with AVSC to link the ACCESS Taita-Taveta subproject in Kenya with AVSC-trained sectional doctors to provide NORPLANT<sup>®</sup> and other more permanent methods in a remote, underserved area. CBDs can counsel on these methods and make referrals.
- Nigeria - Since November 1994, all CAs involved in the USAID/Nigeria program have worked as implementing partners (IP) of the USAID/Nigeria Integrated Health Services Delivery Program. As partners, they are jointly planning subproject interventions, developing integrated training and IEC activities, participating in joint baseline surveys, and developing a strategy to address the needs of a conservative Muslim population.
- India - ACCESS initiated informal discussions with women leaders from five NGOs to brainstorm advocacy strategies for reproductive rights. The group is conducting background research on which to base its action plan.
- ACCESS funded documentation for Parivar Sewa Sanstha - Marie Stopes International (PSS) and Social Marketing for Change (SOMARC) activities that will be used to educate leaders and communities on the effectiveness of these approaches.

In addition, ACCESS has collaborative activities in process or planned with more than a dozen organizations, including the following: the Population Council, JHPIEGO, CARE, John Snow, Inc./MotherCare, John Snow, Inc./Service Expansion and Technical Support (SEATS), Save the Children, The EVALUATION Project, Population Services International, Centers for Disease Control and Prevention, AIDS Control and Prevention Project (AIDSCAP), Johns Hopkins University/Population Communication Services, WELLSTART, RAPID, Initiatives, Planned Parenthood Federation of Nepal, and the Asia Foundation.

CEDPA has also collaborated with government programs and the United Nations Population Fund (UNFPA), Overseas Development Agency (ODA), United Nations Organization for Women (UNIFEM), GTZ (Association for Technical Cooperation, a

German development agency), World Health Organization, and the Center for African Family Studies.

In the countries where it has offices, ACCESS serves as an active member in the Interagency Forum on Women in Development (WID) in Nigeria in relation to subprojects and advocacy, the NGO Interagency Forum in Nepal, and the Integration of STD/AIDS into Family Planning Working Group in Kenya. (See Appendix L - ACCESS Project–Collaboration Matrix, Africa & Asia.)

### Concerns

- CAs participating in the India IFPS Project have not created opportunities for active collaboration and intellectual discourse on cross-cutting issues related to the project. CEDPA's role as liaison CA does not include orchestrating this level of collaboration. The expectations of SIFPSA and USAID discourage CAs from formally initiating these activities.
- The ACCESS liaison role as defined and in the context of the current management of the IFPA project by SIFPSA does not allow ACCESS to use its comparative advantage in carrying forward project coordination and activities in an optimal way.

### **Recommendation**

24. ACCESS field offices should continue to provide leadership in interagency collaboration and in-country learning networks, including those that provide clinical backup. Through such networks they could share their IEC and training materials, management systems, and service delivery experience as well as learn from the experience of other NGOs and CAs.



### 3. Organization, Management, and Finance

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#### 3.1 Organizational Structure

**How have the organization, management, and finances of the ACCESS project influenced its accomplishments and capacity for future expansion?**

##### Accomplishments

##### 1. Headquarters

CEDPA has made dramatic progress in its management systems since its last evaluation. Their management systems are currently as sophisticated as those of any development organization with an emphasis on the monitoring of quality services and the use of state-of-the-art office systems. Procedures manuals cover personnel and financial systems as well as project start up protocols (an institutional development checklist, a proposal development format, guidelines on baseline surveys, among others) as well as subproject monitoring forms for reporting both financial and service delivery statistics.

##### 2. Field Offices

ACCESS is the largest of CEDPA's programs and supports field offices in Kenya, India, Nepal, and Nigeria. One component of the ACCESS project was development of regional offices. While ACCESS has developed field offices, all staffed by expatriates, none has become a true regional office. This is largely because many subprojects have been transferred to other organizations due to changes in USAID policy. The East Africa regional office is generally viewed by staff as a Kenya office though they do provide technical assistance and support to a new project in Tanzania. The India office was originally planned to be a regional office for South Asia but the staff have not had time to support Nepal as planned. There are country offices in Nepal and Nigeria. The first office that was opened in Egypt was later closed in 1993. However, a new office in Egypt is now open under a USAID/Egypt grant to CEDPA for the Partnership Projects for Girls and Young Women.

It is unquestionably more effective for ACCESS to have field offices. All USAID Missions who were contacted commented on the importance of having ACCESS nearby for collaboration and discussion. In each Mission, ACCESS staff were highly praised for their cooperation with Mission objectives and flexibility. With the development of country offices, the resources of headquarters can be more effectively used in training of trainers and technical assistance to model subprojects that can then pass the skills and expertise on to others in-country. With the establishment of the offices, much more training and technical assistance has been carried out by alumni and subprojects. Having country offices has made ACCESS much more sensitive to the local situation and is a natural extension of the relationship CEDPA has with its alumni. While it has taken considerable time for the headquarters staff to get the office systems in place in

Kenya and India, now that they are in place, much less travel from headquarters will be needed.

### 3. Finance

The ACCESS project has an excellent financial reporting system. Subprojects send both financial and service delivery data to their country office which consolidates them and sends them to Washington. In Washington, finances are reconciled and returned to the field. Subprojects appear to make good use of the financial and program data. The analysis of data is being devolved to the field and Nigeria is already doing its own reconciliation. Recent changes in the budget reporting system has added a column to the percentage of the remaining budget which has been helpful for project staff to monitor their financial status and for headquarters to identify problems.

#### Concerns

- Although ACCESS is on the road to regionalization, it has not yet been fully implemented, and some issues remain to be resolved. Most specifically, ACCESS needs to incorporate its regionalization strategy into its overall strategic plan and show how two distinct strategies (the basic model used in most countries and the lead CA model used in India) fit in with CEDPA's goals as an organization.
- Currently each country office is organized somewhat differently and handles ACCESS activities only. The offices would be much more effective if they were CEDPA regional offices and could coordinate all of CEDPA's programs (BLE and training) with ACCESS into a strategic plan for each country. Such an arrangement would require that CEDPA give institutional support to the offices to allow them to travel on non-ACCESS funds for purposes of generating projects and funding from other sources.
- Communication within CEDPA is vertical with most decisions being made at headquarters. The India office has more autonomy than the Kenya office. There is little lateral communication among the field offices. This will be partially resolved with a conference in October in Washington and the introduction of e-mail where available. A CEDPA newsletter is also useful, but tends to be a public relations document rather than an analysis of substantive program issues.
- Communication between ACCESS and USAID could be enhanced through greater focus on strategic issues. Given the regular turnover of the Cognitive Technical Officer (CTO) and USAID staff, finding ways to maintain effective communication remains a challenge. ACCESS semi-annual reports are narratives of activities and do not focus on plan implementation, outcomes, changes or results, nor on the substantive or innovative aspects of ACCESS activities.
- CEDPA has developed an institutional development check list to use with its subprojects but has no such guide for monitoring its own development as an

organization and identifying its areas of weakness. Indicators of process effectiveness would be an important first step.

- USAID/Washington and Kenya expressed concern about CEDPA's overhead rate of 110 percent which is substantially higher than that of other CAs. CEDPA/ACCESS responded to this concern by pointing out that it is not possible to compare CAs with respect to this issue, since each CA calculates its overhead differently. CEDPA's overhead rate of 110 percent is calculated on direct labor dollars, excluding vacation, sick and holiday time. Fringe benefits are not included, nor is overhead taken on any other direct costs, as is the practice of most other organizations. A review of the actual costs in 1994 for the ACCESS project indicated that of US\$5.6 million dollars in total cost, US\$1.1 million was overhead. This was 17 percent of total ACCESS cost in 1994.

Questions were raised about the need for expatriate staff in CEDPA's country offices and plans are already being discussed about ways to increase the use of local staff. In Kenya and Nepal, USAID staff reported their preference for expatriate resident representatives. This raises the question of the role of the resident representative, whether it is to manage a CEDPA regional office or to serve as a liaison with USAID.

The ACCESS project is currently organized by geographic region and does not coordinate effectively with the Better Life Education program.

## **Recommendations**

25. ACCESS should nationalize its field offices as soon as suitable local candidates are located and trained. The exception is India where it may be necessary to keep expatriate staff for a few more years due to the current need for continuity during implementation in a challenging environment. This should be part of the strategic plan to make the offices CEDPA regional offices and give them the support they need to develop new projects and leverage funds from other donors. The ACCESS International Conference in October 1995 should address the issues of regionalization and the role of the national offices.

## **3.2 Strategic Planning**

### Accomplishments

CEDPA undertook a formal strategic planning process with an outside facilitator in 1992. At that time, CEDPA's two main strengths were identified as its training and its alumni network, two elements that must form the foundation for anything CEDPA does. The strategic plan, updated in 1995, presents CEDPA's mission, values, geographic focus, strategies, stakeholders, and describes CEDPA's overall objectives as follows:

- 75,000 girls knowledgeable about life skills and reproductive health
- The gender gap in primary school enrollment closed by 10 percent

- Twenty percent increase in contraceptive prevalence at the national level
- Environmentally sound and healthy communities
- Leadership training for 1,600 development professionals, 70 youth leaders and 560 program managers
- Institutional expertise in gender issues in all CEDPA partners

It is not clear what the target population is or how such objectives as "environmentally sound" communities are to be measured.

In addition to CEDPA's overall strategic plan, each country in which they operate has a country strategic plan. These are part of the ACCESS annual implementation plan and include information on the demography, education, and reproductive health status of the country, along with a background of CEDPA work in the country, a list of achievements in the previous year, and activities to be undertaken in the current year.

### Concerns

- While CEDPA is to be commended for having a strategic plan, the existing one is descriptive and does not include the clear policy guidance expected in a strategic plan. Four of the most important developments for CEDPA--which are regionalization, the decision to accept the position as lead CA in India, establishment of training centers, and a move toward curative care in some subprojects--are not discussed in the plan. The strategic plan is updated annually suggesting that it is a reactive rather than a proactive document. Some of the objectives are unrealistic.
- The organization's current strategic plan does not include clear guidance on what CEDPA does and does not do. The strategic plan should set forth measurable objectives, target countries, and include performance monitoring for each subproject. The monitoring and evaluation system should be linked to the strategic plan. For example, what is the strategy for regional and/or country offices and how does that fit in with CEDPA's overall objectives? How does the decision to serve as lead CA in India fit in with the organization's strategies, and is this a role they hope to play in other countries in the future? Does CEDPA do women's health (secondary and curative) or family planning, and if so, how does this fit in with their mission. These are all important trends within CEDPA that need to be addressed at the policy level but are not included in the current strategic plan.
- The country strategic plans would be more useful if they were well focused on specific issues or problems in each country and set out measurable objectives of progress.

## Recommendations

26. ACCESS produces a large volume of documentation, more than USAID can read, and the project needs to find ways to highlight the most important parts of documents it sends to USAID. This could be done by flagging certain pages or preparing a 2-3 page literature review of all the documents sent during each quarter. Each quarterly report to USAID should address at least one substantive issue with lessons learned, in addition to service statistics. The report should be reformatted to reflect the reinvention and results orientation of USAID and aim to report regularly on improvement activities and results.
27. Over the next two years, CEDPA should consider a major review of the responsibilities of its Washington staff to allow individuals to become responsible for processes rather than geographic regions. This would mean units for sustainability, reproductive health, quality of care, monitoring and evaluation, empowerment, and youth, perhaps using a matrix responsibility chart. This would allow for better integration of programs and, as field offices take on more backstopping responsibility, Washington staff could focus on developing models and systems in each area.
28. CEDPA should prepare a new strategic plan that shows how all CEDPA activities are integrated at the field level, including the Better Life Education project, ACCESS subprojects, and training. The new plan should address the issues of regionalization, the role of curative health care and clinic services, the activities and direction of regional training institutes, and whether CEDPA wishes to develop the India model in other countries.

### 3.3 Monitoring, Evaluation, and Use of MIS Data

**What additional research, baseline surveys, evaluations and assessments should be performed to demonstrate measurable impact?**

#### Accomplishments

ACCESS has established a comprehensive subproject monitoring and evaluation system based on the collection of service statistics and supplemented by internal evaluations and studies. All subproject staff are trained by CEDPA/Washington in simple data collection and analysis methods and they are expected to use the information to guide implementation, as well as to inform the ACCESS country office and CEDPA/Washington on a quarterly basis concerning subproject progress and performance. An overview of the system is presented as Figure 2. Key elements of the system are as follows:

Baseline Surveys. ACCESS undertakes baseline surveys for most new subprojects. Whereas previously they gathered information principally related to the percentage of

Insert Figure 2

women in need of family planning, ACCESS now incorporates focus group information from the project sites to assess knowledge, attitudes, and practices related to family planning. This approach has been used, for example, in planning project activities at ten project sites in Nigeria.

Project Monitoring. ACCESS monitors all subprojects on a quarterly basis. CEDPA/Washington trains subproject staff and CBD workers in the collection, reporting and analysis of service statistics. CBD workers gather the needed information from clients using a client registration card and report the information to CBD supervisors and subproject managers. Subproject staff then prepare quarterly reports that provide information on the following: new clients, referrals, resupply/revisits, commodities dispensed, parity of new clients and referrals, dropouts and reasons for dropout. Five of the subprojects report on age of new clients and referrals. The quarterly reports are sent to CEDPA field offices for the initial review and then to Washington for entry into the ACCESS database and preparation of computer generated graphs and tables. The analyses are returned to field office staff who in turn review the findings with subproject staff. Subprojects appear to be visited regularly by in-country or regional staff. The evaluation team reviewed numerous in-country monitoring reports prepared by field staff.

Midterm Assessments, Final Evaluations, and Special Studies. The wide array of ACCESS internal evaluations, special studies and other assessments generated by the project's monitoring and evaluation system is presented in the bibliography of this report, Appendix M. Many of these studies represent ACCESS's efforts to examine progress, results and impact, based on ACCESS service statistics and other special data gathering efforts and to identify lessons learned during implementation. Currently, ACCESS has four studies under way: a process evaluation of STDs/AIDS integration into the FLPS project in Nairobi; the need for adolescent reproductive health services, highlighting the YWCA service model; the impact of combined literacy and family planning on the empowerment of women in Nepal and the impact of training managers and field-workers in gender. It is also in the process of conducting an evaluation of the GSCPT project in Gujarat through two local firms.

Identification of Indicators. Recently, ACCESS has been working to identify appropriate indicators to assess objectives related to women-centered reproductive health services, as well as indicators related to empowerment and sustainability. ACCESS's Quality of Care workshops, undertaken to identify appropriate indicators and approaches for assessing quality service delivery, was discussed in Section 2.1.3., Family Planning Service Delivery.

Data Accuracy. To maintain the integrity and accuracy of the data base, ACCESS has designed and implemented a training program to train subproject managers and staff on the MIS and the collection of data. The project has conducted regional MIS workshops in Asia and Africa and worked closely with field staff in the regions. Following the training, ACCESS staff has also provided technical assistance to individual subprojects, based on their expressed needs and the MIS and progress reports which are submitted

quarterly. There is an ongoing process in the field offices to verify the accuracy of the data prior to submission to Washington for input and analysis.

An external review (Trayfors, 1995) of ACCESS data collection and the MIS found that it "seems to be working well in many respects and, while there is certainly room for improvement, it is a valuable source for useful information pertaining to CEDPA's field activities. This system should be continued, but upgraded." This review summarized data confidence as follows:

- High Data Confidence: parity, new client trends by each subproject
- Medium Data Confidence: referrals, revisits, method switching
- Low Data Confidence: dropouts

The team probed the issue of data accuracy both in Washington and the field. CEDPA/Washington and the field related instances of their becoming aware of inaccuracies and the steps they took to retrain and assist CBD workers and staff in the proper procedures. At the project site for the replication of the Dairy Cooperatives project in UP, the team questioned the project director for the procedures used to examine the accuracy of service statistics. He related three separate procedures used to examine data accuracy, one involving a check by supervisors to compare supplies by CBD workers actually distributed and the data entered on the client registration card. Nevertheless, given the very difficult conditions under which the data are gathered (frequently by CBD workers with little education), there is little doubt that ongoing efforts to assess and improve data quality will continue to be very important to enhance performance monitoring and management decision making.

### Concerns

- ACCESS's monitoring and evaluation system is not linked to the objectives of a strategic plan. At present, while a wealth of studies have been undertaken or are in the planning stage, the monitoring and evaluation system is being less than optimally used for management and improvement purposes. ACCESS will need to consider its strategic objectives, and then design the priority evaluations and studies needed to assess the achievement of objectives.

### **Recommendations**

29. ACCESS should prepare a performance monitoring and evaluation plan that is closely linked to the ACCESS strategic plan. Whatever studies are undertaken should reflect strategic objectives and related outcomes. The plan should specify the ways that monitoring and evaluation will be used to assess achievement of objectives with appropriate indicators that are specific, measurable, area specific, reasonable, and time bound (SMART) and develop a system for monitoring achievements towards those objectives. ACCESS should continue its current thoughtful efforts to identify indicators to assess objectives related to empowerment, reproductive health services delivery, quality of care, and sustainability, and also aim at ensuring that the indicators reflect specific



strategic objectives. Cost and efficiency information should be gathered regularly through monitoring and evaluation.

30. To ensure managers' and donor confidence in the accuracy of outcome and other data, ACCESS should undertake an in-depth review in the field of select subprojects to examine the accuracy of service statistics. Since procedures for regularly examining data quality and retraining data gatherers as necessary are already in place, ACCESS should document procedures related to assessing and improving data accuracy and periodically discuss these procedures in semi-annual reports.

## 4. Future Directions

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### 4.1 ACCESS Comparative Advantages

ACCESS's comparative advantage stems from the following elements:

1. Holistic and integrated model for sustainable development with its emphasis on empowerment. The literature indicates that women's empowerment through education and training has significant health and other outcomes. Many of these outcomes, including those of the Better Life Education project, are yet to be measured. CEDPA has already begun to examine ways to assess and contribute to women's empowerment and program outcomes and could continue to advance understanding of these linkages.
2. Capability to link knowledge of service delivery issues at the local level with advocacy. Recent research has shown that policy reform is more likely when local communities and indigenous groups understand and feel ownership of the issues. When these groups become actively involved in advocacy, genuine reform is more likely. ACCESS's linkages with local NGOs and communities, and its knowledge of service delivery issues at the local level, combined with its relationship to the in-country network of CEDPA alumni who can act as local and national advocacy groups, give ACCESS a unique comparative advantage, as well as enhanced credibility with national and international policy-makers.
3. Commitment to management training and participatory management. Efforts to strengthen community family planning programs, focused on underserved populations, especially those of isolated and home-bound potential clients, will require highly effective leadership and management capabilities far surpassing those required for simpler delivery systems or in situations of less resistance to family planning. Family planning program managers will need the requisite skills in modern management techniques, to lead organizations structured with incentives making them at risk for the success of their programs, as well as information systems and tools which strengthen managers' abilities to design innovative strategies, implement efficient and effective programs, and monitor progress and problems on an active basis. ACCESS addresses the need for effective managers trained in modern management methods.
4. In-country network of trained women (CEDPA alumni). The sunk costs of creating the CEDPA network were paid over many years of investing in the training of more than 4,000 trained managers who are now graduates of CEDPA programs. The marginal cost to maintain the network itself is no longer a significant cost factor. The alumni network is a valuable resource whose potential for impact has yet to be fully developed.

The design of a possible follow-on project should take into consideration CEDPA's comparative advantage. Thus the following might be considered as areas for future focus:

- A focus on education in family planning and reproductive health for youth, ages 10-18 (both boys and girls), which would incorporate the lessons and experience of the Better Life Education project;
- Support for the development of strategic, country-specific plans for advocacy by the CEDPA alumni, based in part on the lessons emerging from service delivery subprojects, to enhance credibility with policy-makers; and
- In management training and strategic planning, a focus on entrepreneurial training and activities.

## **4.2 Models of Partnership**

The ACCESS project works with two basic models. The first, used in all countries except for India might be called the basic CEDPA model which has been described in Section 2.1. This model builds on the grassroots organizations that serve women. In some cases, these are existing family planning projects that need help with training, quality of care, or CBD training. In other cases they are income generating or literacy programs that already have access to a large number of women, typically women who are asking for family planning information. ACCESS channels the resources of CEDPA (training, technical assistance, and funding) to these organizations while simultaneously training individual women in leadership skills that lead to self-confidence and empowerment. One of the criticisms leveled against ACCESS is that its subprojects are small and even if they were all very successful, the overall national impact would be low.

The second model, used in India, is ACCESS's attempt to address that criticism. In India, CEDPA is the lead among 17 CAs that are charged with the implementation of a statewide family program in Uttar Pradesh, one of India's most populous and least developed states. In India, CEDPA has over 100 alumni and has, over the years, funded a number of subprojects there. Two of these are part of the ACCESS project, one in Gujarat and another in Bihar. In the development of USAID's Innovations in Family Planning Project, both projects were chosen for replication in UP (as discussed in more detail in Section 2.1.3. on Service Delivery). The idea is that ACCESS would identify partner NGOs and train them in the organizational and service skills they need to implement the project statewide. Toward this end, ACCESS has replicated one of its partner agencies, PPRC in Uttar Pradesh. PPRC is one of CEDPA's oldest development partners and under the ACCESS project has established a training center in UP and is training CBD workers (through TOT) and supervisors, and providing management training to NGOs throughout the state of UP.

Theoretically, the India model would allow ACCESS to scale-up and provide an infusion of technical assistance and service skills to grass-roots organizations throughout the

state. The design of the project is such that technical assistance and training must go through a new parastatal organization, SIFPSA which is not yet fully staffed and trained. Until that happens, ACCESS and the other CAs working in population in India are limited in the work they can accomplish as they are prohibited from approaching NGOs directly and from establishing an office in UP.

The India model may also be viewed as an effort to target ACCESS and CEDPA resources more strategically than has been the case in other countries. This could be done by identifying areas with high need and by giving intense assistance through TOT and management assistance that would reach a large number of NGOs rather than the specific subprojects of the traditional CEDPA model.

ACCESS is working with other models that appear to have potential for scaling-up and broader impact. One model involves ACCESS's work with training centers and emphasis on the training of trainers (as in Nigeria) to reach many more grass-roots organizations with its training and technical assistance. A second model, also in Nigeria, involves ACCESS's work to provide family planning through a broad range of "existing networks" such as urban markets, the informal business sector, women's cooperatives, trading and religious associations and agricultural workers. Thirdly, and again in UP, ACCESS is developing a strategy to work with "consortiums of NGOs," rather than with one single NGO at a time, and to strengthen lead NGOs in the consortium as an effort to reach more groups at the local level. Fourth, in Nepal, ACCESS is providing family planning through the infrastructure of the Red Cross, a long-established organization in Nepal that has offices and sites throughout the country.

In summary, the traditional CEDPA model works very well in empowering women and providing quality service delivery, but its reach is limited to that of the subprojects it sponsors. The India model has the potential for making better use of CEDPA's resources by targeting a specific area and working to improve all the service delivery in that area rather than just a specific partner NGO. Because of the issues related to the IFPS project in India, the model has not yet been adequately tested. USAID/India is undertaking a major management study which, it is to be hoped, will remedy some of the problems that now constrain ACCESS and the other CAs. The other potential models for effective service delivery will have to be carefully evaluated and documented through ongoing monitoring efforts.

## 5. Conclusions and Recommendations

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(Four major conclusions and recommendations are listed here. For a listing of all recommendations, refer to the Executive Summary.)

### 5.1 Service Delivery and Advocacy

#### Conclusions

ACCESS's holistic and integrated model for sustainable development and quality service delivery—with its emphasis on empowerment, participation and institutional strengthening—is an effective approach for increasing contraceptive prevalence. ACCESS's ongoing relationship with the in-country network of CEDPA alumni, coupled with its linkages with local communities, and its knowledge of service delivery issues at the local level, gives CEDPA a unique comparative advantage with respect to advocacy for family planning and reproductive health. Recent research holds that reform is more likely when local communities understand and feel ownership of the issues and can initiate advocacy at the grassroots.

#### **Recommendation**

1. ACCESS should continue to focus on both service delivery and advocacy. USAID should consider ways in which CEDPA can play a leadership role in the design, implementation, and management of family planning and reproductive health service delivery in the nongovernmental sector, especially in situations where USAID can employ CEDPA's comparative advantage. CEDPA/ACCESS should encourage its alumni to use lessons and experience from service delivery in its advocacy efforts.

### 5.2 Sustainability

#### Conclusions

ACCESS has taken important steps toward developing an integrated sustainability strategy. The strategy includes a systematic process of interventions which strengthens institutions' management, financial, and human resource systems and mobilizes community support and ownership.

#### **Recommendation**

2. To continue to make progress in both institutional and financial sustainability, and to increase efficiency and cost-effectiveness, CEDPA should: (a) develop its capacity to determine the full costs of service delivery and institutional strengthening as well as monitor cost trends in CEDPA itself and its subprojects;

and (b) continue to develop collaboratively with its partners' agreed upon plans for financial sustainability, as part of a strategic emphasis on entrepreneurial thinking and activities.

### **5.3 Management**

#### Conclusion

ACCESS has excellent management systems in place and the institutional capacity to support additional subprojects. Nevertheless, the CEDPA strategic plan does not yet optimally guide management decisions and implementation.

#### **Recommendation**

3. (a) USAID should seek opportunities to introduce and implement CEDPA's tested service delivery strategies on a larger scale, in additional country settings, to increase coverage and contribute to broader (provincial or state) results and impact. (b) CEDPA should develop a new strategic plan with clear and measurable objectives that is monitored on a regular basis and is linked to an evaluation plan and costing studies.

### **5.4 Future Directions**

#### Conclusion

The design of a possible follow-on project should take into consideration CEDPA's comparative advantage.

#### **Recommendation**

4. CEDPA should consider adding to its current program the following as areas for future focus: (a) a focus on education in family planning and reproductive health for youth, ages 10-18 (both boys and girls), which would incorporate the lessons and experience of the Better Life project; (b) support for the development of strategic, country-specific plans for advocacy by the CEDPA alumni; and (c) a strategic focus on entrepreneurial training and activities.